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ABSTRACT

An exploratory study was conducted to examine the ways in which existing programs or service delivery systems have adapted to meet the needs of homeless families with children. Key issues and model and innovative approaches were identified prior to study site visits in five cities: (1) Atlanta (Georgia); (2) Baltimore (Maryland); (3) Boston (Massachusetts); (4) Minneapolis (Minnesota); and (5) Oakland (California). This volume includes the site visit reports for each of the five cities and the profiles of programs visited in each city. In Atlanta, study personnel interviewed representatives of state and local government agencies, advocacy groups, and service providers, and toured facilities, where possible, for 10 shelters, clinics, and programs. Program profiles are presented, with an overview of the city's efforts, for six Baltimore programs. The site visit in Boston reviewed the efforts of eight programs. In Minneapolis, eight programs or shelters were studied. The site visits in Oakland investigated the services of seven programs. An appendix contains a glossary of related terms. Ten exhibits list the site visit participants and describe the service delivery flow in the site visit cities. (SLD)

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ED 385 670

HOMELESS FAMILIES WITH CHILDREN: PROGRAMMATIC RESPONSES OF FIVE COMMUNITIES

VOLUME II
SITE VISIT REPORTS AND PROGRAM PROFILES

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Submitted to:

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A. Glossary of Terms

Acknowledgements

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The study team is also indebted to the many energetic and dedicated people serving homeless families with children who were willing to share their experiences with us. Many of these individuals had tremendous responsibilities and overwhelming workloads; that they took time to share information with Macro was greatly appreciated.

Macro study team members and authors of this report are Lela Baughman, Thomas Chapel (project manager), and Carolyn Rutsch. Martin Kotler also contributed to this study.

Executive Summary

I. Introduction

In July 1990, Macro Systems, Inc., under contract to the Office of the Assistant Secretary for Planning and Evaluation (ASPE) of the U.S. Department of Health and Human Services (DHHS), was commissioned to undertake an exploratory study of the service system for homeless families with children.

It is widely believed that throughout the country a fairly large number of programs exist to respond to the needs of homeless families; one purpose of this project was to facilitate community-based efforts by identifying and describing particularly promising programs and practices and analyzing the roles of various levels of government and of the voluntary sector in providing services. The study objectives included the following:

- Describe the specialized needs of homeless families, and provide insights into the prevalence of this population and factors contributing to family homelessness.
- Identify five program configurations designed to meet the needs of this population that are widely regarded as model approaches.
- Examine these program configurations in-depth.
- Identify policy issues and barriers affecting programs for homeless families.

The study was intended as an exploratory study to examine the ways in which existing programs or service delivery systems have adapted to meet the needs of homeless families with children. Through a comprehensive literature review, telephone discussions with national experts who are familiar with issues and programs serving homeless families with children, and telephone discussions with providers, advocates, and agency officials in selected cities that are experiencing a significant problem with family homelessness, the study team identified the key issues, model and innovative approaches, and made preliminary selections of cities for in-depth site visits.

The study team conducted case study site visits in five cities: Atlanta, Georgia; Baltimore, Maryland; Boston, Massachusetts; Minneapolis, Minnesota; and Oakland, California. In each city, the team identified for interviews those programs and agency contacts who could best provide a comprehensive picture of the service delivery system for homeless families with children. The findings of the site visits were used to identify policy and service delivery issues related to meeting the needs of homeless families.

This final report is in two volumes. Volume I begins with an overview of the problem of family homelessness based on a review of the literature and discussions with national experts and prominent service providers, advocates, and public officials in major U.S. cities. The core of the first volume is the presentation of cross-site findings from the five site visits.

These findings are grouped into two categories: findings related to coordination of services and findings related to comprehensiveness of services. The final chapter of Volume I discusses issues and barriers that were discovered during the site visits. These are program and policy concerns that have influenced the state of homeless services in the past and will shape the options for the future.

Volume II of the final report includes the site visit reports for each of the five cities and the profiles of the programs visited in each city.

II. Cross-Site Findings

In examining the service system for homeless families in five diverse cities, the site visit team found themes and patterns in the provision of services and the larger context within which programs operate. Two categories of findings emerged from the site visits: coordination of services refers to the degree to which the elements of the service system are integrated or planned at the public agency, service provider, and/or participant level; comprehensiveness of services is the degree to which the service system includes the broad array of services that homeless families might need and provides these services in a way that makes them most accessible by homeless families.

Six findings related to coordination of services emerged from the site visits. They include the following:

- At the public agency level, there is very little coordination among agencies in dealing with the problems of homeless families.

- At the service provider level, every city has one or more coordinating mechanisms such as a coalition or task force. Although public agencies may participate actively in these, the coalitions are usually provider- or advocate-driven.

- Although cities offer many sources of information and referral to services, there is very little integrated delivery of services through mechanisms such as one-stop shopping.

- Coordinated and comprehensive services planning, such as case management, is a major gap in the service system for homeless families. The case management that does occur is usually provided by service programs as an adjunct to their regular services.

- Lack of followup of homeless families once they leave the service system is a major problem. Even though followup can help ensure that families are stably linked to services, many homeless families do not want to be followed once they leave the service system.

- Outcome evaluation of programs for homeless families is rarely done and would be difficult to accomplish because of uncertainty about program goals and inability to track outcomes or attribute successes to program efforts.

Besides the findings on coordination of services, the following 13 findings emerged from the five sites concerning the comprehensiveness of the service delivery system. These include the following:

- Although housing services are often conceptualized as a continuum, the cities visited do not have a true housing continuum in place that includes emergency shelter, transitional housing, and services-enriched permanent housing. Usually one or more of the components of the continuum are either missing or suffer from inadequate capacity to meet the demand.

- Even when the components of the continuum are in place, the links between the various components are often either weak or nonexistent. As a result, homeless families are often left to navigate the system on their own and may not receive the amount and degree of services they need to move through the continuum successfully.

- Support services for homeless families are often provided in an inappropriate setting within the housing continuum. In particular, services are often concentrated in emergency shelter even though families may remain for only a brief time and their immediate crisis makes them less receptive to services aimed at long-term needs such as employability or personal problems.

- Health care is the service most commonly provided by programs set up specifically to serve homeless individuals and families. Separate programs are often needed because operational characteristics and lack of capacity in mainstream health care services renders them inaccessible to homeless families.

- The McKinney Act education provisions have greatly improved homeless school-age children's access to the public school system and to the school that is in the best interest of the student, mainly because the cities visited have voluntarily chosen to provide transportation to schools.

- Preschool programs, including Head Start, are not serving the majority of homeless preschool-age children because of lack of capacity and because hours of operation and program performance incentives regarding attendance and followup tend to exclude homeless children.

- Links to employment and training programs are weak; adult members of homeless families rarely benefit from these programs. Many are unskilled and may have multiple problems, but current funding is not flexible enough to address their multiple needs and program performance incentives regarding job placements tend to discourage programs from serving homeless adults.

- Lack of adequate child care once families leave the homeless service system is one of the most frequently cited obstacles to independent living for homeless families.

- Child protective services does not remove children from their families for homelessness alone. However, the parents' homelessness does make it difficult to reunite families that have been separated for other reasons.

- Eligibility screening and application assistance for WIC and for major entitlement programs such as AFDC, Medical Assistance, and food stamps, is routinely being provided to homeless families by a variety of homeless service providers.

- Demand exceeds supply for almost all types of substance abuse treatment to which low-income people have access. The problem is especially severe for homeless mothers with children; very few residential treatment programs are able to accommodate children of mothers in treatment.

- Battered women are often counted as part of the homeless family caseload, but the domestic violence system and homeless service system are separate and the links between the two systems are not strong or visible. In many of the cities visited, the homeless shelter system often receives the overflow from an overburdened domestic violence shelter system.

III. Policy and Program Issues and Barriers

Based on the observations of the site visit team and the comments of providers, advocates, officials, and experts in the five cities visited, the following policy and program issues and barriers emerged from the site visits:

- Unless incomes go up or rents go down, poor families will be at-risk of repeated episodes of homelessness.

  Measures which act to raise incomes of the poorest of poor families or increase the availability of affordable housing attack homelessness at its roots. While AFDC benefits and housing subsidies are necessary, they are shorter term palliatives; building self-sufficiency is the longer term solution. Actions which will help raise incomes, lower barriers to higher paying jobs, or lower rents include the following:

  - Emphasize education and skills training which will improve the access of families to higher-paying jobs.

  - Use the homeless service system as a case-finding opportunity for targeted employment and training programs.

  - Extend subsidized child care for homeless women into their period of permanent housing.

  - Encourage Federal preferences for homeless families in making assignments to public and subsidized housing.

  - Encourage flexibility in use of funds for move-in assistance such as first and last months' rent, security deposits, or rent arrearages.

- In the long run, the homeless services system is only as effective as the mainstream services to which homeless families can be linked.

Developing a comprehensive and coordinated system of homeless services is counterproductive if homeless families will be returning in a few months to underfunded, overwhelmed mainstream services. There is a need for continued linkages to services such as subsidized child care, Head Start, developmental services, prenatal care, and substance abuse treatment.

- Lack of attention to the special needs of families while they are homeless creates barriers to access to mainstream services.

While homeless families resemble their tenuously-housed counterparts in most ways, homelessness presents practical problems such as transportation, child care, and lack of informal supports that must be addressed to deliver services effectively. Some adaptations to mainstream programs include the following:

- Encourage flexibility in WIC programs through innovations that address the realities of shelter life for homeless mothers such as modified food packages and shelter-based certification and voucher distribution.

- Allow for modifications in Head Start so programs can accommodate homeless children and families; modifications might include expanded hours of operation or waiving performance requirements regarding attendance and followup.

- Allow for flexibility in use of funds and for modifications in the performance incentives for employment and training programs that will encourage them to serve homeless adults with lower skill levels and multiple problems.

- Encourage States to provide transportation for educational access for homeless students.

- Lack of followup means no one knows if the service system is effective or not.

Among its many advantages, followup can help determine the extent of recidivism among homeless families. Knowing the extent of recidivism is essential to defining the role of the service system for homeless families. Followup can also reduce the need for additional steps in the housing continuum; if families can be followed into permanent housing, support services can be tailored to their needs and gradually withdrawn as they become able to assume more independent lives.

Some ways to enhance followup might include the following:

- Incorporate followup as an appropriate use of funds as it already is for Health Care for the Homeless and Head Start.

- If possible, vest a single entity with responsibility for followup. Ideally this entity should have access to an updated address database, such as the AFDC database, which is likely to include families after their period of homelessness has ended.

  - Where a single entity cannot assume responsibility for followup, encourage programs to track participants at periodic intervals for at least a year using a variety of techniques such as mail-back cards, telephone inquiries, or designated followup staff.

  - Develop incentives for families to stay in contact with the system after they leave services; one incentive might be continuation of services such as child care beyond the period of program participation.

- Services are fragmented and duplicative.

  Human services are organized categorically; unfortunately, the problems of homeless families cross traditional categories. Coordinated services planning, or case management, while not a panacea, is clearly an enhancement. Case management can minimize duplication of efforts and record keeping, vest responsibility in one place, and ease followup so that intensity and mix of services can be varied as the family's needs change.

  Some ways to enhance coordinated services planning might include the following:

  - Incorporate case management as an appropriate use of program funds.

  - If possible, centralize case management in one entity such as a multi-services center. This minimizes the number of case plans being developed for a single homeless family and ensures that families who do not participate in services such as shelter or health care, where case management is currently most likely to take place, have access to coordinated services planning.

  - Develop strong ties between the case management entity, the public housing system, and the entitlement system. Housing and entitlements are the cornerstones of short-term self-sufficiency for homeless families; case planning should be able to offer these resources.

  - Encourage maximum client participation in developing the case plan.

- Inadequate links between services and housing means support services end when they are needed most to sustain independent living.

  Permanent housing is often not under the control of the human service public and non-profit agencies that are such an integral part of the homeless services system. Efforts to carry social services forward once the family is permanently housed may meet with bureaucratic obstacles. One result is the creation of still more steps in the homeless housing continuum to prepare the family for permanent housing that they can maintain without support. A few modifications would make permanent housing more accessible even to homeless families with multiple problems:

- Encourage services-enriched housing models that house the family permanently and provide a mix of support services that are tailored to the needs of the family.

- For special needs such as substance abuse or mental illness, encourage residential programs that can accommodate children while the mother is in treatment or child care options that can provide long-term 24-hour child care.

IV. Summary

The programs and initiatives described in this report represent the best efforts of five diverse communities to address the problems of homeless families with children. There are advantages and disadvantages to the approach taken by each city. While five cities is far too few to draw sweeping generalizations for the rest of the Nation, the information presented in this report is useful in highlighting promising approaches to serving homeless families and in identifying program, policy, and research issues that may warrant further attention.

Chapter I

Site Visit Report

Atlanta, Georgia

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Chapter I. Site Visit Report--Atlanta

I. Introduction

The site visit team selected Atlanta as a site visit to get broad geographical representation in the study sites and because the Atlanta system is characterized by a network of voluntary associations. The site visit team was interested in learning how a system that is predominantly dependent upon the nonprofit voluntary system packages the important services that are needed for homeless families. Georgia, like most of the southern States, does not have high per capita income outside of the major metropolitan areas. This lack of an income base is reflected in a less well-developed and well-funded human services system than in other parts of the country. For example, Georgia does not participate in the Emergency Assistance (EA) component of the Aid to Families with Dependent Children (AFDC) program with the exception of one energy assistance component, and AFDC rates in Georgia are lower than in the other cities visited. The site visit team was interested in learning how services would be provided in an environment without many State resources. Would a dedicated system of homeless services be more likely to develop? Would fewer services be provided? Would the same links be made to mainstream services as in other cities?

II. Overview of Site Visit

The Macro study team conducted interviews in Atlanta between January 28 and February 8, 1991 to explore how the city's service delivery system is meeting the needs of homeless families and children. During the site visit, the study team interviewed representatives of State and local government agencies, advocacy groups, and service providers.

Officials from the following State and city government offices were interviewed:

- Homeless Families with Children Program
- McKinney Education Coordinator
- City of Atlanta Housing Department
- Office of Community and Intergovernmental Affairs, State Department of Human Resources (DHR)
- Homeless Services Coordinator, City of Atlanta Department of Human Services

Staff were interviewed and facilities toured, where possible, for the following service delivery programs:

- Atlanta Community Health Program for the Homeless (ACHPH), which provides mobile and clinic health services to shelters and other locations and coordinates a continuum of care for those with mental illness and/or substance use problems
- Moreland Avenue Women's Shelter, the largest shelter serving women and children in the metropolitan area
- Cascade House, another large shelter serving women and children
- ACHOR Center, a transitional housing program (THP)
- Nicholas House, a transitional housing program
- Genesis Shelter, a new shelter for pregnant homeless women and women who have recently given birth. This program is not yet open.
- Georgia Nurses Foundation Clinics for the Homeless, a health clinic operating out of the Moreland Avenue Women's Shelter
- Atlanta Children's Shelter, a child care program for children of women in shelters or THPs
- Our House, a child care program for children of women in shelters or THPs

The study team also interviewed the staff of the Atlanta Task Force for the Homeless, a policy planning and information clearinghouse on homeless issues in Atlanta, and the staff of the Family Homeless Program funded by the Robert Wood Johnson Foundation. This is one of nine RWJ grants in the nation; the Task Force is the recipient of this grant.

The purpose of these discussions and program surveys was fourfold: (1) to gain a general understanding of the size and scope of the problem of family homelessness in Atlanta, (2) to outline the service delivery system in the city as it serves these families, (3) to describe innovative service programs, and (4) to identify issues and barriers preventing homeless families in Atlanta from receiving the services they need.

Exhibit 1 presents basic information on all interview participants. Exhibit 2 is a flow diagram depicting the main interrelationships in the service system for homeless families. Profiles of the programs visited are attached in the appendix. These represent selected examples of some of the programs that compose the service delivery system in Atlanta.

III. Contextual Issues

As in cities and counties across the nation, in Atlanta there is no single factor responsible for family homelessness. Rather, a mix of system and individual factors combine to increase the risk that an individual or family will become homeless.

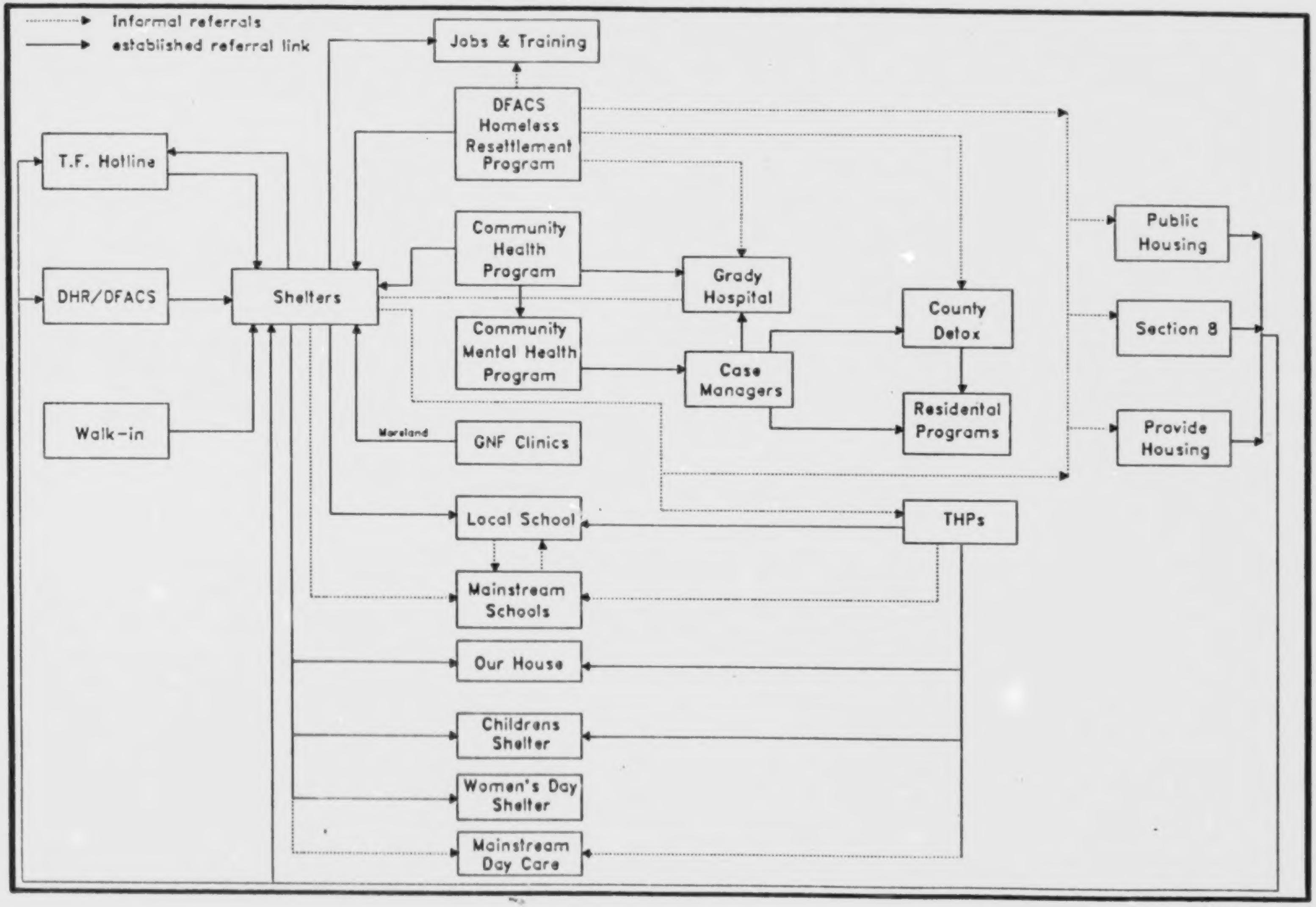
EXHIBIT 1

DESCRIPTION OF SITE VISIT PARTICIPANTS: ATLANTA

Program Name	Organization Type	Services	Toured Facility
Atlanta Task Force for the Homeless	Coalition	Coalition of advocates, providers, and government officials	
Our House	Child Care Center	Dedicated child care for homeless mothers and with children	X
Atlanta Children's Shelter	Child Care Center	Dedicated child care for homeless mothers and with children	X
City of Atlanta Housing Department	City Office	Oversight and facilitation of private development of affordable housing	
Homeless Services Coordinator, City of Atlanta Department of Human Services	City Office	Oversight of funding of city efforts related to homelessness	
Georgia Nurses Foundation Clinics for the Homeless	Health Program	Onsite primary care clinics at shelters and community kitchens	X
Genesis Shelter	Shelter	Shelter and services for parents with newborns; opens in Fall 1991	
Moreland Avenue Women's Shelter	Shelter	Shelter and services for homeless single women and homeless women with children	X
Cascade House	Shelter	Shelter and services for homeless women with children	X
Office of Community and Intergovernmental Affairs, State Department of Human Resources	State Office	Coordination of State funding for homeless programs	
McKinney Education Coordinator, State Department of Education	State Office	Oversight of access and school choice provisions of McKinney Act	
Homeless Families with Children Program	State Office	Case management and resettlement services for homeless families in shelters and THPs	
Nicholas House	Transitional Housing Program	Transitional housing and services for homeless families	X
ACHOR Center	Transitional Housing Program	Transitional housing and services for homeless families	X
Atlanta Community Health Program for the Homeless	Health Program	Mobile primary care services, mental health case management, substance use treatment services	

EXHIBIT 2

FLOW OF CLIENTS THROUGH THE SERVICE SYSTEM: ATLANTA


Informal referrals
established referral link
Jobs & Training
DFACS Homeless Resettlement Program
T.F. Hotline
DHR/DFACS
Walk-in
Shelters
Community Health Program
Community Mental Health Program
Moreland
GNF Clinics
Grady Hospital
Case Managers
County Detox
Residental Programs
Public Housing
Section 8
Provide Housing
THPs
Local School
Mainstream Schools
Our House
Childrens Shelter
Women's Day Shelter
Mainstream Day Care

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The approaches to addressing the issues presented by family homelessness are heavily influenced by the social, political, and economic environment. The next section describes the characteristics of the homeless family population, some of the factors related to causes of family homelessness, when and how a response to the problems took shape, and the political and social climate in Atlanta.

A. Size and Characteristics of the Population

Data on the size and characteristics of the homeless population were acquired from provider interviews and from data collected by the Atlanta Task Force on the Homeless.

Task Force data indicate that in 1989, approximately 35,000 to 47,000 persons experienced episodes of homelessness. Of these, about 30 percent were members of homeless families. The data further indicate that the fastest growing group of homeless people is children under 6 years of age.

The homeless family population in Atlanta consists mostly of African-American, female-headed households. According to Task Force data, 52 percent of those requesting shelter in an average month are African-American.

While little data is available on the family population, data on those families served by the Division of Family and Children's Services' (DFACS) Homeless Families and Children program indicate that of 182 families served in 1989, about 10 percent were intact families, about one-third were in-migrants from outside of Georgia, and the average number of children was 2.1. More than three-quarters were unemployed, although less than half were receiving AFDC at the time of the intake.

B. Factors Related to Family Homelessness

Data on factors related to homelessness were acquired from provider interviews, the Task Force and national data.

Economic or Structural. Several informants indicated that most homeless families in their program are victims of eviction--usually for nonpayment of rent. According to Task Force data, 57 percent of those requesting shelter have been evicted. This lack of affordable housing is generally cited as the primary reason for the increasing number of homeless in Atlanta. Downtown development has destroyed many boarding houses and single room occupancy (SRO) housing options. Only one-third of the units that existed only 10 years ago are available today.

While gentrification and downtown development have not affected the housing market for homeless families to the same extent, there are serious affordability issues. Task Force data indicate that the fair market rent (FMR) for a two bedroom apartment in Atlanta is $584 a month. A family of three on AFDC receives $272 a month--about half the FMR. Minimum wage take-home pay is approximately $600 a month.

However, some informants believe that there is more affordable housing in the market than is commonly believed. The problem is a lack of information to link supply and demand. The city recently awarded a grant to the Task Force to explore ways of getting affordable housing information to the homeless population; this effort is described later.

Some informants also believe that rehabilitation of Atlanta's many substandard units could fill much of the affordable housing gap. One catalyst would be project-based Section 8 funding, which would provide an income stream for owners that would be steady enough to obtain permanent financing. Right now, only 100 certificates are project-based; the rest are held by families.

Individual Factors. Although eviction for nonpayment of rent is considered the primary cause of homelessness by most providers, family dysfunction was also cited by some providers as a primary cause of homelessness.

Crack cocaine use and violence have become commonplace among many poverty-stricken areas in Atlanta and are often cited as exacerbating factors of homelessness.

Site visit informants also indicated that many women in shelters are victims of abuse and are in the homeless shelter system because the battered women's shelters are full. Data from the Homeless Families with Children Program indicate that of 112 families served in 1989, about 20 percent involved domestic violence as a contributing factor to homelessness. A statewide Department of Education survey concluded that 38 percent of families had domestic violence as a proximate cause.

C. Development of a Response to the Problem of Homeless Families

In 1981, the mayor of Atlanta appointed an ad hoc task force composed of advocates and bureaucrats to develop some responses to the increasing problem of homelessness in the Atlanta metropolitan area. Prior to that, the response was limited to the voluntary nonprofit sector, primarily in the form of church-run shelters and soup kitchens. The ad hoc task force eventually became the Task Force for the Homeless. By 1985 the Task Force was supported by one staff person, through city funding. A 1984 study conducted by the task force showed that the population of homeless people in Atlanta was changing; there were more females and more families than in the past.

The county governments (Fulton and DeKalb) started providing some funding to support the Task Force in 1985 and the State government's involvement began in 1986. A study commissioned by the State to examine its appropriate role, determined that rather than creating new agencies to deal with needed services, existing agencies could address the issues with the support of additional resources. At that time the Homeless Families with Children Program was created within the Division of Family and Children's Services (DFACS) in the State Department of Human Resources. The thrust of this program is to assist families in shelters to locate and settle into permanent housing and make linkages to existing services.

Atlanta's emergency services for homeless people are largely designed around a shelter system that traditionally has been nighttime shelter only. Recent responses from other service providers have addressed daytime sheltering needs--for example, a day shelter for children, and the women's day shelter. A Task Force priority has been to move the family shelter system towards 24-hour sheltering. This would become the basis for providing more social services within the shelter.

D. Political and Social Climate

Overlapping Political Jurisdictions. Overlapping and multiple political jurisdictions tend to interfere with the orderly provision and continuity of services to homeless families in Atlanta. The City of Atlanta is almost wholly contained in Fulton County; however, its easternmost portion is in DeKalb County. The main family shelter was relocated to the DeKalb County portion of the city, yet most of the homeless families continue to originate in the Fulton County portion. This has created problems of coordination and continuity of social services. Although the social service system is State funded and administered by the State, services are delivered at county-based offices. Whenever a family changes counties, its members must reenroll for social services, establish new case worker relationships, and relate to a different set of agencies. School relationships are equally complex. Separate local education agencies administer schools in the City of Atlanta, Fulton County, the City of Decatur, and DeKalb County. Because many families cross school district lines once they become homeless, their child cannot remain in the school of origin unless the new school district is willing to assume the costs of transportation. School districts in the metropolitan area, to date, have been reluctant to do this for their own students, much less for students crossing district lines.

Division of responsibilities within the city government is equally complex. Although city ordinances control locations of housing sites, the city has no direct role in providing housing services; its role traditionally has been to facilitate private development. The Atlanta Housing Authority, a separate quasi-government agency, runs the public housing projects and the Section 8 program. Within the city bureaucracy, the housing production function and the housing planning function have been separated into two departments. Some informants believe that the dispersion of housing production, planning, and operation have led to a chaotic and uncoordinated approach to homeless housing issues.

The city has no legal obligation to provide services to homeless families, but has formally accepted the responsibility by being involved in shelter funding. The city tends to work in partnership with Fulton County in funding several shelters: Milton Avenue Shelter, Moreland Avenue Women's Shelter, and Cascade House.

Complexity of Funding Sources. Funding of homeless services is more complicated in Atlanta than in any of the other cities visited, in part because the State does not participate in the AFDC/EA program, which was the central funding source for shelter services in some of the other site visit cities. Funding is a patchwork quilt of Federal and State money channeled through assorted State, city, county, community-based nonprofit, and service-providing entities.

State funding consists of a combination of State appropriations and assorted McKinney funds for which various State agencies are the receiving agency. One of the most important State-funded programs is the State Homeless Services Program which provided $200,000 for State shelter programs. Initially, these funds were intended to support shelters, but, with the onset of Federal Emergency Shelter Grant (ESG) money, the program was refocused to assist with services planning and advocacy. Among other uses, the program now funds the Task Force for the Homeless and similar efforts. The Homeless Families with Children Program funds resettlement services in three counties, while other State money funds case management for health, mental health, and substance use services in selected counties and projects.

The State of Georgia Residential Finance Authority (GRFA) is the receiving agency for the Emergency Shelter Grant (ESG) funds and distributes this money using a formula based on bed space allocation. The State Department of Human Resources (DHR) is the receiving agency for the Emergency Community Services Block Grant funds, which are channeled to the network of local Community Action (CAP) agencies.

County funding for homeless services tends to come from Community Development Block Grant (CDBG) funds, as well as some of the aforementioned State appropriations to counties for homeless services.

The city's contribution to homeless services is funded by a combination of its Community Development Block Grant, city general funds, and its entitlement district formula funding under the Emergency Shelter Grant. The city has tended to use the ESG funds for special projects such as the Milton Avenue Shelter, while the CDBG money is distributed as competitive grants.

The FEMA funding (Emergency Food and Shelter Grants) is distributed directly to non-profits by a special Board.

The complicated funding sources made it hard to understand the budgets of most of the programs visited. Informants also complained about the complicated reporting requirements that result from having these multiple funding sources.

Other Factors. Regarding public attitudes, no informant saw the backlash against homeless people that has been predicted nationally. Most felt that there has been more response by the community, including volunteer support, in recent years, although others felt that the response by business and government had diminished.

The amount and aggressiveness of advocacy efforts on behalf of homeless people has increased. Housing for the homeless was a major issue in the recent mayoral campaign. The impact of facility construction for the 1996 Olympics on neighborhoods and social problem has generated a broad-based coalition of low-income housing supporters, and talk by the convention and visitors industry groups of creating a "vagrant free zone" in the downtown area--a common discussion topic 2 years ago--seems to have dissipated for the moment.

IV. System Coordination Efforts

Atlanta has a number of system initiatives at the government agency, service provider and individual family levels that contribute to coordinated service delivery to homeless families with children.

A. Coordination Efforts at the Agency Level

Among providers, advocates, and government officials, there is a widely shared philosophy of linking the homeless population to already existing services; however, mainstream services are already overburdened, and, as was already mentioned, coordination is difficult in the Atlanta area because of overlapping jurisdictions of the city government and two county governments.

Within government, the team found no projects or collaborative efforts directed at linking public agencies; however, the relevant city, county, and State agencies all participate in the Task Force and its topic area teams. Indeed, this integration of the bureaucracy into the main coalition was more extensive in Atlanta than in any of the other cities visited.

B. Coordination Efforts at the Provider Level

There are several statewide collaborative groups at the provider level. Georgia has an Interagency Council on Homelessness that meets bimonthly. There is also an advocates' statewide task force. The Georgia Resource Network for the Homeless consists of providers, advocates, and bureaucrats.

The Atlanta Task Force for the Homeless is the most visible effort at coordination and includes providers, advocates, and government officials. The Task Force has developed teams divided by topic areas to coordinate specific responses and recommended approaches to identified problems. Teams include welfare, mental health, health, housing, employment, veterans, volunteers, shelter, and county government. Many, if not most, of the innovative programs in Atlanta had their genesis in a Task Force team.

Over the years, the credibility of the Task Force has increased with all parties. The Task Force collects and publishes most data on homelessness; its numbers are beginning to be accepted by planners rather than being seen as inflated advocate estimates as in some other cities.

One recent initiative that requires coordination of providers and government officials is the Homeless Families Program funded by the Robert Wood Johnson (RWJ) Foundation. Atlanta is one of nine cities awarded competitive grants to demonstrate projects that link housing and social services for homeless families. In Atlanta, the Task Force for the Homeless is the grant recipient. The project will provide Section 8 subsidized housing to

140 multiproblem families who will be congregated in three apartment clusters around the city. Each cluster will be staffed with a social services coordinator who will do case management; the clusters will also act as informal support structures for the families. The project is just getting underway; successful implementation will require the coordination of DFACS, the Housing Authority, and a variety of State agencies and voluntary providers around the city.

C. Coordination Efforts at the Family Level

In Georgia, as in most States, AFDC recipients are not assigned a case worker unless there is an additional social service issue such as child abuse/neglect or adult protection. Consequently, there is no organized system of case management in the metropolitan area as a whole; however, the Homeless Families with Children Program comes closer to public case management than any program we found in the cities visited. This program, funded by State money to DFACS offices in three urban counties, including Fulton and DeKalb, provides a variety of resettlement services to accelerate the movement of families out of emergency shelter and to ensure that homeless families are linked to permanent housing and social services in their new homes. The program operates very differently in the three funded counties, and only the Fulton DFACS program comes close to providing case management. In Fulton, case workers are assigned to each of the family shelters and provide intake, services planning, and screening for entitlements. The case workers help expedite documents and paperwork needed for entitlements, can provide security deposits or first month's rent, and are able to supply basic furniture once the family moves to permanent housing.

While the goal is placement in housing, the relatively small caseloads (1:50) allow the case workers to facilitate obtaining social services for the client including accompanying clients to service offices. The Fulton program keeps cases open until the families are settled stably in the new community--currently about a year after intake and getting longer. This is the longest period of active follow-up that the team found in any program in any city.

Other than the Homeless Families with Children Program, the amount of case management carried out on behalf of a sheltered family depends on the shelter and other service providers encountered by the family. The Transitional Housing Programs (THPs) do a great deal of coordinated case management, but shelters tend to provide information and referral only. A unique aspect of the Atlanta Community Health Program for the Homeless is provision of case managers who specialize in mental health and substance use case management. This is the most innovative program of its kind that the team visited and is described in more detail later.

No attempts at collocation of services or one stop shopping were found in the Atlanta system, and, to our knowledge, none were planned.

V. System Comprehensiveness

This section presents the service system components and discusses how each addresses the needs of homeless families, describing the primary service providers or actors, and how services are provided, noting their comprehensiveness, capacity, and barriers and gaps in service delivery. It should be noted that the following comments are general impressions based on interviews with a limited number of government agency representatives, service providers, and advocates.

A. Housing Continuum for Homeless Families

Emergency Shelter. There are 80 emergency shelters in the Atlanta system with a capacity of 3,200 beds, including year-round and winter-only facilities. Many are nighttime shelters only. About one-third of the shelters (comprising more than half the beds) charge a fee; this is a far higher percentage than in other cities visited.

Eleven of the emergency shelter facilities serve only families or women with children. Three more serve this population among others. Shelter sizes range from only a few families to 150 people. Almost all of the family shelters have common living and sleeping spaces. Consequently, restrictions on intact families and older male children are common. All shelters have shared baths, kitchens, and dining areas.

There is no centralized intake system in Atlanta. Although the Task Force operates a 24-hour hotline that partially serves this function (13,000 people were referred through the hotline last year), there is no requirement that placement in shelters go through the hotline, and referrals also come from DFACS, self-referral, Travelers Aid, and United Way. Shelters keep the hotline informed of their census on a regular basis so that the Task Force can monitor available beds and compile an unduplicated monthly census.

The emergency shelter system also includes 30 motels that participate in a national hospitality industry program. These serve an overflow function. The Task Force assumes the liability for the hotel; in return, space allowing, the hotels will house people for free for up to three nights.

Shelter lengths of stay vary; 90 days is the highest found by the site visit team. Length of stay criteria are set by the program. Since the funding sources are mixed, no single funder can impose length of stay criteria as in some of the other cities visited.

Transitional Housing Programs (THP). There are eight transitional housing programs which serve families or women with children exclusively. In addition, two others serve them among other populations. Most programs are congregate site projects; two are smaller scattered site projects.

The Task Force differentiates transitional programs from emergency shelters based on: (1) the extent of the criteria the client has to meet for admission, and (2) whether the program is accessible for emergency admissions through the hotline. THP providers generally distinguished themselves from emergency shelters based on the extent of their case management systems, their levels of social services staffing, their hours--THPs are open 24-hours per day--and their extended lengths of stay. Most THPs in Atlanta have lengths of stay of 1 year to 18 months.

Transitional housing programs get referrals from a variety of sources, including self-referral, DFACS, and shelters. However, no formal linkage exists between emergency shelters and transitional programs.

The THPs visited have varying degrees of formal links to support services and varying levels of services in-house. However, a service plan and goal setting process is at the core of all the programs, unlike the shelters.

Permanent Housing. There are three housing authorities that affect homeless housing services for families--one each in the two core urban counties of Fulton and DeKalb and one in the City of Atlanta. The three differ regarding application preferences for homeless families. Informants indicated that only the Atlanta Housing Authority accords preferences to homeless families. Without that, access to housing would take 6 months versus 2 to 4 weeks now. Fulton County's housing authority is just starting to give priority to homeless families, while DeKalb's does not.

Informants provided conflicting information about Section 8 preferences for homeless families. Some claim that there is no homeless preference, others that there is one, but it competes with preferences for those paying more than 50 percent of income for rent, those in overcrowded conditions, and those whose property is condemned. Regardless, only one resettlement worker indicated that Section 8 was a source of housing.

Some of the resettlement workers indicated that, because of the dearth of public options, they have private arrangements with private developers and seek to identify affordable apartments.

For sheltered families, the main links to permanent housing are through the Homeless Families with Children Program. The program provides extensive services to families in Fulton County shelters, including expediting AFDC--which eases access to public housing--first month's rent and deposit, and furniture. Unfortunately, the largest family shelter is in DeKalb County where resettlement services are less extensive. In that shelter, workers and DFACS staff only provide information and referral to housing.

Most AFDC mothers go into public housing because they need a setting where housing costs are determined as a percentage of income. Employed families and those in THPs are steered towards private housing.

Another recent effort to link homeless families with affordable housing is the Task Force's Housing Line. This project was not yet implemented during the site visit, but has since become operational. The Housing Line lists affordable vacancies throughout the city. Many of these are vacant apartments that were initially renting at levels that were not affordable for homeless families. However, rather than leave them vacant, landlords have chosen to reduce the rent and list the vacancies with the Housing Line. In some cases the Task Force has been successful in securing waivers of security deposits or other modifications to the rental agreement that would make the units more affordable for homeless families.

Vacancies are updated monthly; 5,000 copies are distributed to soup kitchens and shelters. In the first month of operation, the list included 700 to 800 vacant units at 100 properties; in the second month, 1,700 units at 200 properties. In the first month, about 40 households found housing through the list; in the second month, 44 households found housing. Task Force staff estimate that 90 percent of the homeless households finding housing are families.

B. Health and Developmental Services

Developmental Services. Referral sources for developmental screening have been identified by the two child care centers for homeless children and, to varying degrees, by the shelters. However, the availability of programs for developmentally delayed children is not clear.

Health Services. Ultimately, health care for the uninsured and poor populations in Atlanta--and much of Georgia--is sought at Grady Hospital, a public facility supported by a combination of State funds and contributions from Fulton and DeKalb Counties. These services are so overwhelmed and the waits so long--6 to 8 hours for primary care--that a host of health programs serving homeless people, including homeless families, have been established. Before the onset of dedicated health programs, homeless people were often forced to choose between labor, food, and health care, according to informants. Time spent waiting for health care meant time away from searching for jobs and housing and could also result in losing a shelter spot if it conflicted with the time at which they had to return to the shelter to ensure a bed. Long waits such as these are especially difficult for families with small children.

The most visible and widespread health program is the Atlanta Community Health Program for the Homeless (ACHPH), which operates a fully-equipped 33-foot Health Mobile. The Health Mobile goes to 8 to 10 sites per week during the day including soup kitchens, labor pools, the two homeless day care centers, day shelters, and other gathering spots for the homeless. The program also operates three vans that visit sites during the day; one staffed van is dispatched to provide clinic services at a different shelter three nights per week. The Health Mobile can provide most primary care services and is staffed with nurse practitioners, volunteer doctors, health advocates, and social service workers. The night van is staffed with a Health Advocate and a volunteer. The ACHPH is able to make referrals to Grady Hospital specialty clinics, thereby allowing patients to bypass the long waits for primary care. The program also has established referral arrangements with a variety of community health centers for dental, gynecological, and eye care. The program also participates in a WIC demonstration project to provide nonperishable milk to sheltered mothers with children.

An innovative ACHPH program that provides case management for mental health and substance use is described later.

The Georgia Nurses Foundation operates two health clinics for the homeless. The most recent one, funded with McKinney funds from ACHPH, is located onsite at the largest family shelter. It is open to all homeless persons, but most clinic patients are from the shelter. The clinic is staffed by nurse practitioners and can provide immunizations, tuberculosis testing, sexually transmitted disease (STD) testing, some gynecological care, and screening for referrals. Medical backup is provided by the staff of the Department of Community Health at Morehouse School of Medicine. Residents from Morehouse are on call and spend three hours per week at the clinic, mostly to sign charts and orders.

Referrals are made to Grady Hospital and a DeKalb County primary care clinic in the Kirkwood neighborhood for advanced gynecological services, physicals, and pediatrics. Referrals are also made to the Southside Health Center for primary care and eye care.

In addition to these services, the State provides some direct funding for health services in DeKalb County shelters. Depending on the shelter, some health care professional staff may be available for screening and referrals.

Prenatal care was cited as a major gap by most health informants. Currently, pregnant mothers are sent to Grady or to two other clinics. However, informants felt that continuity of care was lost and that mothers would be more likely to adhere to proper prenatal care if services were accessible through the dedicated programs.

One concern raised by shelter volunteers and a Task Force team was the lack of adequate daytime services for homeless families with mildly ill children or newborn babies. Our House, a day care center for homeless children, addressed this concern by providing three "get well rooms" for families in night shelters to use during the day if their children are sick, and for mothers with newborns. However, program staff report that these rooms are not used as much as originally expected and will probably be converted for other program needs.

Genesis Shelter is a new initiative, still in the developmental stages, that grew out of the need for daytime services for new mothers who were being discharged with newborns just a few days after delivery; however, a feasibility study indicated that full-time shelter was needed. A related concern was the exposure of newborns to the infectious diseases that tend to be common in shelters. When it opens, Genesis Shelter will help women make the appropriate health care linkages and offer 24-hour shelter with support services.

C. Education

Preschool. The Head Start program is not considered a readily available resource for homeless families primarily because it is only a partial day program. Site visit informants indicate that homeless families have a need for full-day programs and it is logistically too complicated for them to use partial day programs. Even for families that would use partial day programs, access is limited by extremely long waiting lists.

School Age. State data indicate that there are from 1,300 to 3,800 homeless children in Northeast Georgia (the catchment area that includes Metro Atlanta). Two-thirds are enrolled in schools when they arrive at the shelter--about one-third each in the local school, another school in the same district, and another school in a different district.

Statewide data indicate that about 80 percent of shelters encourage parents to enroll the child in the local school. While respondents to a state survey indicate that schools are not always willing to enroll students, refusals are not common.

Of all the cities visited, Atlanta has made the least progress in accommodating the spirit of the McKinney Act education provisions regarding access and choice of school. Two years ago, the State hired a McKinney homeless education coordinator whose role has been to troubleshoot. The State has attempted to influence school district practices through persuasion rather than by creating policies or rules that the school districts must follow. Consequently, each local school district approaches the issues differently. Providers and advocates have approached the problem by applying pressure on individual local schools to be responsive to the needs of homeless children in nearby shelters. The Task Force has conducted training among shelter providers to help them learn how to approach the schools.

No school policies explicitly prohibit children from remaining in their school of origin, but the system does not provide transportation to accommodate that. Particularly when students cross district lines for shelter housing, the new school district is not at all likely to pay for transportation to a school of origin in another district. Because the largest family shelter is in DeKalb County, this problem arises frequently for Atlanta's homeless families, most of whom originate in Fulton County. That the problem does not arise more often is attributed by advocates to ignorance of homeless parents of their rights under the law.

Site visit informants indicate that although most homeless children are not attending their school of origin, they are enrolled in local schools. Some advocates attribute this accomplishment to the efforts of the shelter providers and advocates. However, others indicated that the local schools tend to be very accommodating to homeless children. Indeed, some believe that they are overzealous in meeting the spirit of the McKinney Act regarding access and, in the process, do not adequately pursue the option of keeping the child in the school of origin. At times, children received special services in the original school that cannot be duplicated.

Although the local schools tend to accommodate homeless children, their transient status means that they tend to shift from school to school as the family moves. This poses a particular problem when the family moves from one county to another and therefore changes school systems.

After School. A variety of after school programs are available to sheltered children. Many of these are mainstream programs open to all children at the local schools, such as YWCA-sponsored reading enrichment programs at the local school near Nicholas House, a THP. In addition, some of the shelters and transitional programs have developed after school programs for children including such services as homework assistance and tutoring, reading enrichment, arts and crafts, and recreational activities. These programs are staffed with combinations of paid and volunteer staff.

Grants from the State Department of Education to Atlanta Urban Ministry and the Community Justice Resource Center fund after school programs at Moreland Avenue Shelter and Cascade House, respectively.

D. Child Care

The lack of affordable child care was cited as a major gap for low-income families by site visit informants. They reported that it is not uncommon to see newly rehoused and newly employed families go back on welfare because they cannot afford day care. According to the Task Force, the cost of private day care often exceeds the total AFDC monthly benefit.

Child care services have been made available to homeless families while they are in shelters primarily through two resources, the Atlanta Children's Shelter and Our House.
Both facilities were initiated because of concern about the lack of daytime shelter for small children. Both provide full-day child care.

Besides these two dedicated programs, some of the full-day shelters and transitional programs also provide limited child care services on-site. Some informants indicated that child care services are relatively easy for providers to put into place because potential funders find this type of effort attractive. If services are offered free of charge, these on-site programs are not required to obtain State licensing, which has been cited as a hurdle to establishing on-site day care in other cities.

To be eligible for child care at the Children's Shelter and Our House, the parent must be a shelter or transitional housing resident. Our House primarily serves homeless families in DeKalb County and has room for 30 children. It operates on an enrollment basis. The Atlanta Children's Shelter serves Fulton County homeless families and has capacity for 30 children. It operates on a daily first-come, first-served basis, and gives priority to parents who are working.

Other day care resources are offered by Child Care Solutions, a subsidiary of the Save the Children Fund. Child Care Solutions offers a child care resource and referral service and also provides free training for prospective family child care providers. Save the Children's "Home Again" program offers day care assistance for families moving out of shelters into permanent housing; the program provides assistance in finding affordable day care and offers a full subsidy (at a flat rate) for child care for four weeks after leaving the shelter and then two additional weeks at half-rate.

Save the Children is also involved in the Atlanta Task Force's RWJ Family Homeless Program. Their role in the project, which will link social services and housing to families in three clusters of Section 8 subsidized housing, is to provide resource coordination and to encourage and train families to become family day care providers for their cluster.

Once families move from shelters and have exhausted their benefits through the "Home Again" program, there are virtually no subsidized day care options. The PEACH program--Georgia's version of the Federal JOBS program--was paying for day care for participants who were enrolled in training, school, or work. But the State has exhausted its match money for even this program, and no new participants are being accepted.

E. Other Support Services

Homeless families have access to support services through shelters and THPs. Consequently, the breadth and depth of social services depends upon the shelter, its staffing, and the links it has made with other agencies. Typical support services include parenting and life-skills training, parenting support groups, and housing search assistance. Less common as onsite programs are job training and basic education.

THPs and shelters differ in the types of support services they can offer and the way in which these are staffed. In general, the THPs are able to staff these services with their own professional staff, and the services are often part of the service plan developed in conjunction with the client. However, even THPs depend on volunteers for these services. At Nicholas House, for example, the weekly mandatory group has a curriculum that varies; some weeks the meeting is staffed by paid program staff; and other weeks, by volunteers. The program also depends heavily upon mainstream volunteer services such as Narcotics Anonymous and Alcoholics Anonymous to meet clients' support services needs.

The shelters are even more dependent upon volunteers to provide support services. At Moreland Avenue Women's Shelter, for example, staff run the weekly mothers groups, but volunteers run the group sessions the other nights of the week.

Support services are rarely mandatory in the shelters, but at least some services are mandatory in all the THPs visited.

Families in Fulton County are linked to outside support services through the case workers with the Homeless Families with Children Program. While the program has no established linkages with agencies, caseworkers' knowledge of the system often facilitates access for the client.

Homeless people participating in some of the ACHPH special programs for mental health or substance use also receive a variety of support services; these programs are explained below.

F. Employment and Training

Employment links are among the weakest part of the Atlanta system. As mentioned, PEACH has exhausted the State match for subsidized day care and is not accepting any new participants. This had been a major incentive for enrolling in education, training, or employment programs.

The shelters and transitional housing programs vary in terms of the availability of services to provide or assist clients in making linkages to training and education programs. Nicholas

House, one of the THPs visited, was approved as a GED site, but was unable to secure funding. As a GED site, the program would have received funding for staff and for child care. Currently, the program's residents are referred to mainstream county services. However, most have child care and transportation problems that hinder their full participation.

Many site visit informants expressed some concern that while some training opportunities are available, the focus is often on skills that will lead only to low paying jobs, instead of training that will provide a leap in skills, ensuring better paying jobs.

One problem with current mainstream training programs is that their duration does not always coincide with the shelter or THP duration. Consequently, if the shelter discharges the client before training is completed, the client is often left without supports such as child care that are necessary to complete the training.

As in most cities, the involvement of the Private Industry Council (PIC) and the Job Training Partnership Act (JTPA) in providing services to homeless persons has been mixed, mainly because of JTPA placement quotas. However, the Task Force has been working recently with the PIC to foster targeting homeless persons and with the JTPA program to target homeless veterans. The Task Force's employment team is now planning a job listing database.

G. Other Program Linkages

Child Welfare and Protective Services. Homelessness is not considered *de facto* environmental neglect in Georgia. Indeed, several informants indicated that the biggest issue related to Child Protective Services (CPS) is CPS's reluctance to take the child out of the environment when the provider felt it was warranted. As in other cities, advocates indicated that if a mother has lost her child to the CPS system for other reasons and then becomes homeless, it is very difficult to have the child released while the mother is in the shelter.

Entitlement System. According to the Task Force, 64 percent of women with children in shelters already receive AFDC benefits, and 54 percent receive food stamps. Several of the shelter providers indicated that many of their clients do not have these entitlements in place because they have been in doubled-up living situations, have moved to Atlanta from out of State, have recently lost the benefits for a variety or reasons, or have not been able to produce the paperwork required for application. A major service of the Homeless Families with Children Program is to expedite the paperwork and documents necessary for entitlements. In Atlanta, AFDC is especially important, not only because of access to other entitlement programs, but also because it eases access to public housing through the Atlanta Housing Authority.

WIC coverage is checked by social service workers in several settings; ACHPH participates in a special WIC demonstration project to distribute nonperishable milk to mothers in shelters.

All of the shelters visited screen for eligibility for entitlements during the intake process and instruct clients on how and where to apply. One of the shelters visited offered AFDC and WIC application processes onsite through the Homeless Families with Children Program.

Substance Abuse Service System. All informants agreed that outpatient programs were not very effective in addressing substance use issues; even 28-day programs are often not long enough. Yet, as in most cities, there are few inpatient treatment options for homeless women with children, unless they are willing to give up their children. This lack of residential care makes some very innovative programs inaccessible to these women.

Most programs refer those with substance use issues to the public programs at the Fulton County and DeKalb County Alcoholism Treatment Centers which offer detoxification programs and inpatient and outpatient treatment programs. There is severe undercapacity in the inpatient treatment programs, even if accommodations were available for homeless women with children.

The ACHPH has built strong referral links to substance abuse agencies, providing detox and inpatient treatment at county expense, recovery residential care through a combination of county and ACHPH funds, and an innovative after-care program through a joint venture of a local SRO and one of the recovery residences. Some of this is financed through vocational rehabilitation funds to aid recovering persons in their job search. Currently, none of these options is accessible to women with children because of the lack of residential programs.

Recently, a few new options have been created for women with children. While they will not enable women to bring their children into treatment settings, they will provide for extended child care during treatment without involving CPS or the foster care system. Child Care Solutions/Save the Children is one such program and is able to arrange for child care for the duration of the 28-day program. The Granny House is a CPS-operated program in one of the housing projects. Officially, CPS has custody of the children while the mother is in 28-day inpatient treatment, but the children are cared for by trained "grannies" and it is understood from the start that CPS will return the children at the completion of the mother's treatment.

Mental Health Service System. Many shelters, THPs, and health care programs refer mental health clients to one of the community health centers (Southside) or to the Grady crisis psychiatric clinic. They served rarely established links. The Moreland Avenue Women's Shelter has two social workers onsite because a large number of its single women residents are chronically mentally ill.

ACHPH has one of the more innovative approaches to mental health care. McKinney funds funneled through the county (since assumed by the State) support two case managers. These functioned initially as transitional case managers for institutionalized State hospital clients who were being discharged to the community without a housing option or a link to a mental health center for community care. The case managers worked with the hospital to identify the homeless clients ahead of time and to try to build these links before discharge. In time, the county case workers have been able to take on these responsibilities, and the case managers have evolved into community resource specialists who work with shelters and private and public case workers to create resources in the community for homeless people with chronic mental illness problems.

Domestic Violence Service System.

Not investigated.

VI. General Issues and Barriers Related to Service Comprehensiveness

Atlanta's response to the problem of family homelessness has some identified strengths as well as service gaps and other barriers to a comprehensive and coordinated service system. Following is a summary of the major strengths and barriers that were consistently mentioned among several of the site visit informants and observed by the site visit team.

A. Strengths and Innovative Efforts

There are several innovative efforts and strengths in the Atlanta system:

- The Task Force for the Homeless includes providers, advocates, and bureaucrats. This is unusual and has avoided some of the litigious atmosphere both between government and the advocates/providers and even between advocates and providers that was often the case in other cities.

- The substance abuse and mental health links of the ACHPH are very innovative; unfortunately, they do not serve homeless women. However, the extended child care options that are beginning to appear and that do not involve the foster care system offer considerable promise.

- Child care options for sheltered women are well-developed; unfortunately, they disappear once women leave the shelter.

- The Homeless Families with Children Program is an innovative method of combining services to help move people to permanent housing.

- The Genesis shelter, when it opens, will offer innovative care for pregnant mothers and newborns.

B. System Gaps and Barriers

System gaps and barriers in Atlanta include the following:

- As in most cities which the team visited, affordable housing and affordable day care are the major gaps in the system. There are gaps in followup and case management, although they are not as common as in other cities visited.
- Atlanta's system is dominated by nighttime shelters to a far greater extent than other cities. Full-day shelters are needed to build better links to social services.
- More dedicated prenatal care is needed.
- There are no skills training programs targeted specifically to low-income women. Programs that serve homeless people tend not to train them for jobs with sufficient salaries to retain housing. In some case, lack of coordination among day care, shelters, and training programs means that the durations often do not coincide and women often must leave training programs because their day care and other supports disappear.
- Residential programs for substance abuse for women with children are a major need.
- Overlapping and multiple jurisdictions interfere with the coordination and continuity of services.
- Because program funding is so complex for Atlanta programs, reporting requirements from various funding sources are often contradictory and always time consuming.

Program Profiles

Atlanta, Georgia

Moreland Avenue Women's Shelter

Organizational Issues

The shelter is one of several homeless programs operated by the Christian Council of Metropolitan Atlanta. Founded 6 years ago in Fulton County, the shelter was relocated 3 years ago to church space in DeKalb County and currently occupies the third floor of a church school building.

Capacity of the program is 100 to 125. The facility includes space for 47 single women and 20 to 25 families. Sleeping quarters are in communal space with shared bathrooms. Enrollment on a typical night is around 90 people.

The shelter does not keep a waiting list; entry is first-come, first-served, although if a person has been there the prior night, a place is reserved until the end of the intake period.

Points of Entry

Moreland Avenue provides nighttime shelter only. Because sleeping arrangements are located in common living space, the shelter cannot accept intact families and prohibits males older than 12 years and all male visitors.

Residents typically hear about the shelter through word-of-mouth, other shelters, referral by their DFACS case worker, or the Task Force hotline. No approval or voucher from the county is required.

At intake, the resident fills out a simple form that includes referral source, various entitlement coverages, insurance, goals, and how the shelter can help.

Service Delivery

Shelter intake each day begins at 4:30 p.m. Residents can cook their own dinner in a separate room with hotplates until the communal dinner is served. Meals are prepared by the full-time staff cook, except for the scheduled nights each month when groups and churches prepare dinner.

There is nightly programming on a variety of topics including weekly mothers' groups, singles group, a children's program, legal clinic, and twice weekly Bible study.

A health clinic, staffed by nurse practitioners from the Georgia Nurses Foundation, operates each day and serves both shelter residents and other homeless people.

Many of the single women at the shelter are chronically mentally ill. Grady Hospital supplies two social workers who work to assist these women. While active substance users are not admitted, the staff acknowledges that substance abuse issues are a problem for many of the residents. The Narcotics Anonymous and Alcoholics Anonymous groups have been a response to that; also, the clinic and social workers have limited access to county facilities.

An after-school program is provided for children through a combination of paid staff and volunteers; a social services desk is staffed by two master's level social workers (MSWs) from Grady Hospital. The two MSWs are only for the single-women's groups.

Residents must vacate the shelter each morning. A van transports the residents to downtown Atlanta to temporary labor pools and the Women's Day Shelter. From there, those who are working or searching for jobs can take their children to the Atlanta Children's Shelter for full-day child care.

The shelter has a strong relationship with the local elementary school and is generally able to smooth the way for a new child's enrollment.

Maximum length of stay is 90 days, and most residents tend to stay for the maximum duration. The staff tries to warn residents 30 days in advance to start looking for permanent arrangements. In general, the residents go to public housing with the Atlanta Housing Authority, which accords priority to homeless families.

The shelter has reverted to a 90 day maximum compared with a former more flexible policy about length of stay. The staff felt that too many people were relying on the shelter as permanent housing and were not trying to help themselves. Residents are also limited to two stays.

Coordination and Effectiveness of Services

Very little case planning is carried out by the shelter staff. The intake form asks for goals and how the shelter can help the resident reach their goals. Through the social workers and the mother's group, the staff and volunteers try to help clients work on the goals.

Effectiveness is defined as the provision of room and board. A variety of services are available, and the staff believes that enough is provided to help anyone who wishes to be helped. A formal evaluation has not been done, and little data on the disposition of residents who leave the program is available. For most, the shelter is a way-station to get their bearings while they wait for permanent housing.

Financial Issues

The shelter's funding sources include: The City of Atlanta (40 percent), DeKalb County (40 percent), Georgia Residential Finance Authority (7.5 percent), Federal Emergency Management Agency (FEMA) (7.5 percent), and private donations (5 percent).

Most funding is reimbursed based on an approved budget. However, FEMA recently decided to shift to a per diem-based reimbursement system.

Staffing

The shelter has the following paid staff: full-time cook, full-time director, part-time relief cook and housekeeper, part-time coordinator of volunteers and activities, and part-time after-school coordinator. In addition, the United Methodist Church conference supplies another staff member for the after-school program; the clinic supplies the nurses and Grady Hospital supplies the social workers.

Barriers and Issues Identified

With more funds, the staff would prefer to stay open during the day and develop day-time activities, including some on-site employment. There were plans to open a substance abuse unit for women with children, but the program could not secure funding.

Moreland is the largest shelter in the metropolitan area and draws heavily from Fulton County. The move to DeKalb County has disrupted the delivery of social services for many of the residents who originate in Fulton. Although Georgia's social services system is State-funded and administered, the offices are county-based, and residents who cross county lines must be reintegrated into the DeKalb system.

Cascade House

Organizational Issues

Cascade House is a YMCA-affiliated program located in a building that formally served as a firehouse. It has been in operation as a night shelter for families since 1985. In 1989 it began operation as a 24-hour shelter for women with children. The YWCA also operates two transitional housing programs.

Cascade House has room for 60 people. Fifty spots are for long-term residents (45 days) and 10 are reserved for emergency over-night stays. The bottom floor is an open area that includes a living room area, dinning area and kitchen. The sleeping quarters are located on the second floor and consists of a large open area with beds and individual lockers for storing personal items. Some cribs are available for infants, folding mats are also used for toddlers and small children when there are not enough cribs available.

Cascade House does not impose any limits based on size of the family or age of the children. Their goal and philosophy is to keep families together.

Points of Entry

Referrals come primarily through the Task Force hotline and self-referrals. When the family first arrives a brief intake assessment is done by the house manager on staff. A more in-depth intake is later completed by the human services advocate. Staff keep the Task Force informed about who is residing at Cascade House so that the hotline can stay up-to-date on availability of beds.

The facility is on the public transit line. Because sleeping space is not in private quarters, the facility cannot accept intact families.

Service Delivery

Cascade House offers its residents a safe, clean living environment with meals, laundry facilities, and shower facilities. An array of social services are also offered, undergirded by a strongly held philosophy of fostering empowerment and responsibility among those they serve. As such, the services that are provided are considered optional and much of what they offer is referral to community resources. The human services advocate meets with each family individually to discuss personal goals, future plans and helps them to explore options and identify existing resources to meet their needs.

Some of the services that have been offered on-site include parenting support groups; budget/finance workshops offered by Georgia Extension Services; and health-related seminars offered by the Black Women's Health Project and the American Cancer Society. The application processes for AFDC and WIC are also offered on-site, and staff from the Department of Family and Children's Services come to the shelter on a regular basis to offer counseling and search services.

Day care is provided on-site, Monday through Friday, from 9:30 a.m. to 11:30 a.m. by volunteers from Warren Methodist Church. The Church also provides tutors in the afternoons for the school-age children. Families can also work out cooperative babysitting agreements, but must have a signed agreement showing that someone has taken responsibility for the child. Parents may not leave their children in the shelter unattended.

The Atlanta Community Health Care Program medical van makes scheduled stops at the shelter and provides some primary care and most referrals to secondary care.

Cascade House is a 45-day program and most residents stay for the full period of time. Residents are expected to participate in household chores and adhere to the facility rules, which are read to them at intake and signed. Clients may stay at Cascade House as long as they adhere to the rules. Automatic eviction occurs for curfew violations, possession of drugs or weapons, or causing a disruption that effects the entire house.

As a matter of policy, a family cannot receive services at Cascade House more than once per year. When families do try to use the service a second time, Cascade provides three days of emergency shelter while the family locates another facility.

Coordination and Effectiveness of Services

Case planning is done by the human services advocate at intake. They do not adopt a role of overseeing that the family follows a certain plan of action, but limits their role to providing options and resources.

Cascade House does not offer any followup services once the family leaves the program unless they move into one of the two YWCA transitional housing programs. Residents are asked to leave a forwarding address so Cascade can forward any information that comes to them after they have left.

Effectiveness is not monitored beyond process measures. Staff report that the majority of families go into public housing after leaving Cascade House. Some move on to other shelters, but outcome information is anecdotal.

Financial Issues

The annual budget is around $165,000. Funding sources include Fulton County (38 percent), United Way (22 percent), city (18 percent), GRFA (9 percent), FEMA (4.5 percent), and private individuals and business donations (7.5 percent).

Staffing

Staff include a program associate, four house managers, five on-call staff, a human resources advocate under contract for 12 hours per week, and volunteers. The house managers rotate shifts so that there is one manager on duty for a 10-hour period.

Barriers and Issues Identified

Program staff point out that many of the entitlement program requirements (e.g. WIC, food stamps) operate on the premise that people have permanent housing; officials need to update these rules to reflect the realities of homelessness.

Another concern raised was that although there are plenty of training programs to which to refer clients, they are often not used, primarily because they do not lead to the right kinds of jobs.

ACHOR Center

Organizational Issues

ACHOR Center, which began operation in February 1988, is a residential transitional program for women and their children. It was founded by Sister Marie Sullivan under the auspices of the Christian Council of Metropolitan Atlanta. It has since become separate from the Christian Council. The name is derived from a biblical word meaning "door of hope."

ACHOR Center is located in a three-story building that is divided into three adjoining residential suites. Each suite includes a common living room area on the first floor and separate bedrooms with shared bathrooms on the first and second floors. Two-bedroom suites are available for larger families. The kitchen and dining facilities are located on the basement floor.

ACHOR Center can house up to 78 people, which typically represents about 27 families. ACHOR does not accept men into the program and the age limit for boys is 12 years. The living quarters can accommodate families with up to 5 children.

ACHOR has served approximately 130 families since it opened.

Points of Entry

Referrals for the program come from shelter directors, the Task Force, and self-referral. Families must fill out an application and go through a two-step interview process before being accepted into the program. The application process designed to identify families who will share the philosophies and goals of the program, considers the person's housing situation (must truly be homeless), work history, social history, and references. Acceptance into the program is a joint decision of the program director and case manager. It typically takes around 24 hours from the time of the initial application to move into the center.

Service Delivery

Services offered by the program represent a mixture of on-site and referral resources including job skills training, personal and leadership development skills, parenting skills, one-on-one tutoring, day care services, an after-school program, basic adult education, on-site training programs, employment counseling and placement, housing placement, and medical services.

The program is very structured. Persons accepted into the program are expected to be committed to making a change; within the first 30 days of residence clients are expected to be employed or enrolled in an education or training program.

An on-site day care center is licensed by the State and is open from 7:30 a.m. to 6:00 p.m. Its capacity is 64 children and it serves both ACHOR residents and the surrounding community. Day care is free for ACHOR residents, and fees for the community are based on a sliding fee scale. Usually 35 to 45 of the children enrolled are from ACHOR. Families can continue to use the day care center when they leave the program, in which case the sliding fee scale is applied.

Some education and training has been offered on-site including math, English, and typing, but this service is currently on hold because of lack of funding. The program hopes to restore this component soon and would also like to offer GED basic education on-site.

ACHOR has established linkages for referral and on-site service provision with a number of training and education-related community groups including the Private Industry Council; PEACH, the Georgia version of the Federal JOBS welfare reform program; the Supportive Employment Project; Atlanta Area Technical School; and the Psychological Studies Institute.

ACHOR hopes to add drug abuse counseling and psychological counseling for children and women. Although drug users are not allowed into the program, it remains an issue and they would like a mechanism in place to help address it.

ACHOR is designed to provide housing to families for up to 9 months--this period can be extended on a case-by-case basis if deemed necessary. The average length of stay is 5 1/2 months.

Residents are required to attend weekly parenting classes and weekly community council meetings to address general residential issues. Occasionally, residents are asked to leave the program due to noncompliance with rules and regulations.

Persons leave the program when permanent housing is located. The majority (60 percent) move into subsidized apartments, 30 percent move into public housing, and the remainder (10 percent) find private market housing.

Coordination and Effectiveness of Services

ACHOR has a case manager on staff who assists the women in setting goals and makes referrals to appropriate services needed to meet those goals. The case manager schedules regular meetings with the residents to keep the case plans updated. The focus of case planning is to help the families get back into the mainstream.

Followup services are continued for a year after leaving the program and consist of regular contact and an annual reunion.

Success is measured as placement in education/training and in permanent housing. ACHOR estimates a 75 percent overall success rate. Of the 130 women who have been involved in the program, 88 found jobs while in the program and 41 were placed in training programs that subsequently led to jobs.

Financial Issues

The annual operating budget is about $523,000. Over half of the program's revenues come from McKinney funding. Other funding sources include Fulton County DFACS and special appropriations, City of Atlanta, Save the Children, Child Care Food Program, Georgia Residential Finance Authority (GRFA), Federal Emergency Management Agency (FEMA), day care fees from residents, and rent from the residents--30 percent of their adjusted income.

Staffing

There are a total of 14 staff persons. The development officer, program director, case manager and educational coordinator make up the administrative program staff. The remainder of the staff include the day care center teaching staff.

Barriers and Issues Identified

The lack of enough alcohol/substance abuse treatment slots was one barrier cited by program staff. A related concern was that treatment programs are not of sufficient duration to really address the problems.

Insufficient funding was also cited as a continuing issue; however, ACHOR staff feel that their program has been very fortunate thus far. Staff also indicate that they would like to see a more coordinated and defined service network. Although furniture banks exist and there are resources for utility deposits, first month's rent, etc., there don't seem to be enough resources easily accessible to meet the needs. ACHOR is fortunate in that they can turn to their church sponsor for assistance for residents when they find permanent housing.

Our House

Organizational Issues

Our House grew from the concern of several family shelter volunteers about the lack of adequate day care for mothers and children in night-only shelters. The Altanta Task Force for the Homeless formed a broad-based group to look at this issue; expanding targeted child care was the proposed solution and Our House opened 1 year later.

Our House is located in a renovated house donated by a Decatur church. It is licensed by the State and has room for 30 children. There is a waiting list, although there are usually no more than two to three children on the list at one time.

Points of Entry

Residents of DeKalb County shelters, transitional housing programs, and one battered women's shelter are eligible to enroll their children in Our House. Children from other metro Atlanta shelters are eligible on a space-available basis. Enrollment is based on a first-come, first-served basis; however, once enrolled, children retain their space so long as the center rules are observed.

The center is open from 7:00 a.m. to 6:00 p.m., Monday through Friday. Since November 1988, Our House has had a van which picks up children at three of the four family night shelters in DeKalb County and two nearby rapid transit (MARTA) stations. Parents are responsible for picking their children up at the end of the day. The van will take the child and parent back to the MARTA station.

Service Delivery

The program provides full-time day care, free of charge. Day care includes educational activities, two meals per day and outdoor activities in the large fenced playground adjacent to the facility. Medical screening is provided through the Atlanta Community Health Care Program medical van. Actual medical treatment, including immunizations and the administration of antibiotics, is offered by a nurse practitioner under the supervision of a physician. Our House also provides referral services and support to families. When the family first enrolls, the family resource coordinator holds a resource conference with the parent or parents to assess goals, formulate steps to take to reach goals, and work out transportation issues. Referrals have included such services as DFACS, public housing, food stamps, and specialized health care, as appropriate. The program also refers parents to parenting classes offered by the Kirkwood clinic and the GED program and parenting classes at Carver High School.

In addition to the day care space, Our House has three "get well rooms" for sheltered mothers with mildly ill children and no place to go during the day, as well as for mothers with newborn babies. These rooms have been used most by mothers with newborns, but in general they have not been used as much as was expected.

Our House hopes to add additional space to expand their capacity to 34, as well as to accommodate storage needs, parenting classes, and a space for parent and staff training.

Families can generally keep their children at the center for up to 4 months, although duration is flexible depending on the family's situation. The longest stay has been 6 months. Children who are enrolled must attend regularly, or the parents must notify the center if the child will not be attending. If the child is out for 3 days without notification, the family loses their space.

Coordination and Effectiveness of Services

The family resources coordinator does case planning if that is not already being provided by another source. Some shelters provide case planning/management services and Our House wishes to avoid duplicating this service. In some cases, staff meet with the family on a regular basis; the frequency depends on the particular needs of the family, but can be as often as once a week.

Once a family relocates to permanent housing, Our House staff provide some assistance in finding affordable day care. Other than this, no followup services are provided.

As of December 31, 1990, Our House had served a total of 514 children from 298 families. Of these families, 256 found employment or were enrolled in a training program and 149 located permanent housing.

Financial Issues

The annual operating budget is approximately $209,000. The majority (73 percent) of the program budget for the first year came from McKinney funding. This year, the majority (60 percent) came from Community Development and Block Grant (CDBG) funding. The remainder comes from county funding, State funding, foundation grants, and fundraising efforts. They anticipate becoming even more dependent on funding from churches and private donations.

Staffing

Program staffing includes a full-time director, a part-time family resources coordinator, one full-time lead teacher, 4.5 FTE caregivers, and a full-time person that serves as cook and fills in as a caregiver when needed. The program also has a van driver who works 2 hours per day.

Barriers and Issues Identified

Program staff find that many families are unable to find suitable affordable day care options when they move into permanent housing. Often, they fill the need for day care with tenuous arrangements that may easily fall through, such as care provided by family members, neighbors, or friends.

Staff expressed concern that many funding sources provide start-up funds, but do not provide continuation funding. This pattern may encourage too many new programs to start without having the necessary community resources to continue the service. The program director feels that it may be better to evaluate programs and continue funding those that prove to be effective.

The program director indicated that the various reporting cycles for the multiple funding sources pose an enormous administrative burden because of separate reports, reporting periods, and data requirements.

Atlanta Children's Shelter

Organizational Issues

The Atlanta Children's Shelter was initiated as an Atlanta Junior League project. After conducting a needs assessment concerning homeless child care, in July 1986, the League provided start-up funding of $100,000 to establish the Children's Shelter. The program's mission is to provide day shelter in a caring atmosphere for Atlanta's homeless children.

The shelter is located on the ground floor of the education building at North Avenue Presbyterian Church in downtown Atlanta. It has room for 30 children ranging in age from 1 month to 16 years.

All families staying in metropolitan Atlanta area shelters are eligible to participate in the program, on a daily first-come-first-served basis.

Points of Entry

Parents are responsible for bringing their children to the shelter and must complete a registration/intake process. It is located on a major bus route in Atlanta; occasionally the program can assist families by providing MARTA tokens. Each day, eligible families are admitted to the program, based on established priorities. Employed parents have first priority, and those who have been in shelter and have come previously have a second priority. New enrollees are then admitted on a space-available basis. The number of clients that request services but are unable to participate because of lack of space ranged from 1 to 42 per month in 1990. The numbers tend to be higher during the cold weather months. The program can accommodate only 8 infants, and this is the group that shelter staff must turn away most often.

The Children's Shelter is open from 7:30 a.m. until 5:30 p.m. Monday through Friday and 7:30 a.m. until 4:00 p.m. on Saturdays.

Service Delivery

The program offers daily educational and enrichment activities; breakfast, lunch and an afternoon snack; clean clothes and baths; and medical screening through the Atlanta Community Health Care Program medical van.

The program also offers assistance to parents to help them achieve self-sufficiency, including weekly support groups and training to prevent child abuse and neglect. Frequently, staff help families secure AFDC and food stamps, public housing with the Atlanta Housing Authority, job counseling, and linkage with other community resources. All services offered to parents are optional; participation is not required to receive child care.

The average length of stay for children participating in the program is 4 to 6 weeks. Families can continue to use the Children's Shelter services as long as they reside in a shelter. Once permanent housing is found, they may continue to use the services for up to 2 weeks while they locate other sources of child care. Shelter staff assist the families in locating child care; they maintain a list of licensed child care centers and assist parents in linking with DFACS and Child Care Solutions, a nonprofit child care organization.

Coordination and Effectiveness of Services

When families complete the registration process, they are asked to schedule a meeting with the program's social worker sometime during the next 2 to 3 days. The social worker provides assistance by locating appropriate referral resources, but long-term case planning is not a component of the program.

Effectiveness is measured generally as a process goal. However, staff do maintain data on the number of children returning to the program after families move out of shelter and into permanent housing. During the month of December, 13 children had returned to the program. Over a 4-month period eight children, on average, had returned to the program.

Financial Issues

The program's annual budget is $288,000. Funding sources include the following:

- Religious institutions (10 percent)
- City/county/Federal (8 percent)
- Corporations and foundations (37 percent)
- Individuals (5 percent)
- Fundraising activities (12 percent)
- Board (3 percent)
- Clubs and groups (2 percent)
- Junior League (8 percent)

Staffing

The program staff includes a full-time executive director, a full-time administrative assistant, a full-time M.S.W., 5.5 FTE child care workers, a full-time volunteer coordinator, a part-time cook, and a part-time janitor. Staff are assisted by a pool of 45 Junior League volunteers and 25 to 30 community volunteers.

Barriers and Issues Identified

Staff report that the lack of available resources for families in need, especially affordable housing and emergency financial assistance, creates barriers to success and contributes to recidivism.

Affordable day care is especially difficult to find and subsidized day care is in short supply. Program staff encourage families to apply, but there is usually a 5 to 8 month waiting list for such care. The board of directors is currently looking at the possibility of expanding their services to include transitional day care.

Genesis Shelter

Organizational Issues

The Zale Foundation of Dallas, Texas approached the Temple, Atlanta's largest reform synagogue, about funding a day care project. The Temple formed a needs assessment committee which concluded, in consultation with the Atlanta Task Force for the Homeless, that there was a more pressing need for a shelter for homeless mothers with newborn babies.

The shelter, which will be organizationally separate from the Temple, will be located on the ground floor of a building next to the Temple. A consortium of builders is renovating the space at their cost. The top floor already serves as a night shelter for homeless couples without children. The facility will include private bedrooms with shared bathrooms. The board includes representatives from 13 area churches and the Temple as well as members of the provider community such as Grady Hospital, and the Atlanta business community.

The facility, which is expected to open in the late Fall of 1991, will have capacity for 13 families with two to three children. Mothers and fathers will be accepted.

Points of Entry

Referrals are expected to come from the Task Force and area hospitals, especially Grady Hospital. Applicants will be screened in the hospital. They must agree to set goals, take steps toward independence, and observe the strict rules. The shelter will be a residential program open 7 days per week, 24 hours per day.

Service Delivery

Services include room and board, and a host of social services that are relevant to parents of newborns including on-site family life and parenting classes, health care, and vocational training, referral to community resources, and child care.

The Atlanta Community Health Care Program mobile van will offer services once per week. A church in Sandy Springs will maintain savings accounts for clients and make donations to the furniture bank. When the family is ready to move into permanent housing, the Temple will screen families; for some, they will provide the first month's rent, necessary deposits, and furniture.

The program expects the length of stay to range from 6 weeks to 3 months. However, this will be flexible. Staff will do followup for 1 year and then evaluate needs provided that the family has kept up an ongoing relationship.

Coordination and Effectiveness of Services

Case planning will be done by the social workers on staff. Since the program has not yet opened, the specific components of case planning were not addressed.

The effectiveness goal is to help families leave with self-esteem and the dignity necessary to become independent and productive.

Financial Issues

Estimated costs are $500,000 for renovation and $400,000 for annual operating costs. The Zale Foundation is providing $624,000 over 5 years; an additional $250,000 has been received in a grant from an individual. The program hopes to obtain some McKinney funding and will also need to do fundraising.

Staffing

Proposed staff includes an executive director; two social workers, one to serve as assistant director; four child care workers; a cook; and volunteers.

Barriers and Issues Identified

The program has not yet opened.

Nicholas House

Organizational Issues

Nicholas House began 8 years ago as an overnight shelter in St. Bartholomew's Episcopal Church. After moving to renovated space, it continued to function as an emergency shelter although the plan had been for it to become a transitional housing program and HUD/McKinney funds had been secured for that purpose. Last year, the administration took several steps to move the program in the direction of transitional housing.

The facility can accommodate 13 families in individual bedrooms; families share bathrooms and use a common social area and dining space. There are two families in individual apartments located on a separate floor. The facility is almost always full and is leased for $1 per year on a 10-year lease from St. Bartholomews.

Most program participants originate in DeKalb County, but the facility accepts residents from the entire metropolitan area.

Points of Entry

Until last year, the Task Force hotline considered Nicholas House to be an emergency shelter because homeless families could be placed there on short notice as they could in a church shelter. As the program has upgraded to a THP, fewer residents have come from emergency referrals. The staff reports that the main sources of referral are the facility's waiting list, the Atlanta Task Force for the Homeless, social service agencies, individual churches, and word of mouth. Emergency placements are less common because the program generally knows who is vacating the facility in advance and takes steps to find a replacement family.

Evictions are made for possessing drugs on premises, drunkenness, fighting, too many incident reports, or for failure to meet goals. Three families have been evicted since the program began emphasizing its THP orientation.

The program operates 24 hours per day, 7 days per week. Because families are housed in individual living quarters, there are no restrictions on family composition. In selecting families, the program gives preference to urgency of need and internal motivation. The family must include children.

Service Delivery

The staff distinguishes THPs from emergency shelter on the basis of the amount of case management provided, the types of staff, the comprehensiveness of the services, and the duration of the program. The core of the program is a set of individual goals developed in conjunction with the social worker/social work interns. In assembling services to meet these goals, residents can draw on the following, among others:

- Basic services: The program provides shelter, food, some clothing, linens, laundry area, hygiene products, diapers/formula, medication, and fare cards for MARTA (the public transportation system).

- Health: Volunteer nurses staff a small health room four nights per week. A local volunteer pediatrician, available as backup for the nurses and administrator, also visits on weekends. The Atlanta Community Health Program van comes once a month and can do some screening, testing, and prescribe some medications. The nurses and the mobile van are able to give school immunizations.

  In general, for more advanced care residents are referred to Grady Hospital and local clinics. For dental work, the program's nurse volunteers and social worker make the initial contact.

- Employment: For employment, staff refer the residents to mainstream sources, but are working to emphasize skills and education. Residents are currently limited to dead-end jobs which will never pay enough to meet the fair market rent for the three-bedroom apartment most of them need. The program received approval as a GED site but was not funded. Funding, had it been received, would have paid for a teacher, teacher's aide, and child care. Currently, residents go to the central county facility for GED and skills training programs, but child care and transportation issues often diminish their motivation.

- Day care: Nicholas House has an agreement with a child care program that is dedicated to homeless preschool children. But the parents must be looking for work to be eligible for services. There are also capacity problems and the duration of service does not always coincide with the duration of the program at Nicholas House. Those ineligible or excluded from the special child care program must stay at Nicholas House with their child. The program is investigating providing on-site child care.

- Education: The majority of children attend the local schools, not their school of origin. Relations between the school and the facility are reportedly good. If a child wishes to remain at the school of origin, the facility will supply MARTA tokens to take the child to the nearest school-bus stop.

- After-school: There are several after-school programs available to homeless children through the local elementary school. The local YWCA funds an after-school reading enrichment program and is expanding the program to include Nicholas House for those children who do not attend the local school. In addition, two volunteer teachers tutor every Thursday, and a variety of service groups come on various days of the week on a routine basis to run arts and crafts, tutoring, and recreation programs.

- Housing search: The program provides nothing formal. Residents leave to go to private apartments mainly.

- Group sessions. There are mandatory house meetings each Wednesday. The curriculum encompasses issues relating to house management, living skills, and employment. The program plans to incorporate a 12-step program one week out of the month.

The social workers screen all residents for entitlements and ensure that children obtain services such as WIC.

Currently, those with mental illness issues are referred to the county mental health clinic. Those with substance abuse can be referred to the public outpatient programs or to off-site Alcoholics Anonymous and Narcotics Anonymous programs. In the opinion of the staff, only about one-quarter to one-third of the families in the program have only affordability issues as the reason for their homelessness. Currently the program has few services for those with mental illness or substance abuse issues.

Residents can stay up to 18 months. Staff report that the average stay is 6 months, although information for the last four months of 1990 indicated that the 22 families who left the program during that period stayed an average of 85 days. Residents leave before completing the program because they are able to get a job and can afford the housing. However, the staff believes that some leave prematurely. During the program, staff try to get clients to examine the personal reasons that may have contributed to their homelessness such as mental illness, substance use, or physical health problems.

Coordination and Effectiveness of Services

The staff does an intake and assessment on new residents and develops a plan of action with the family and the social worker. The plan includes long- and short-term goals and a time table. Residents meet with the social worker and/or social work interns once per week for goal setting and review during the first month, and biweekly thereafter. Residents are reassessed at the end of three months.

The amount of followup has been increased since the program began to emphasize its THP orientation. An on-site visit and a telephone followup is done 30 days after the family leaves the program. After 60 days, the program sends a mail-back card for followup. At one year, they expect to send out another card. Thus far, the program finds that former residents stay in touch; recently compiled information on the fate of residents indicates that most are still working and stably housed in permanent housing.

Information for the last four months of 1990 indicate that of the 31 families affiliated with the program during that period, 19 moved to their own apartments or housing, 3 to shelters, and the remainder were still in the program.

Financial Issues

The program charges rent using the HUD guidelines of 30 percent of income after exclusions. But these payments are accumulated into a savings account for the family to build up and use for resettlement upon leaving the program.

Of the total 1991 income of $90,000, 30 percent came from the city and State, 15 percent from HUD, and most of the remainder from contributions including the McKinney THP funding, county contributions, and donations from corporations, churches and individuals.

About 15 percent of the expenses are for salaries, wages and benefits; 7 percent is for food; 8 percent each for utilities, and for transportation (including MARTA tokens).

Staffing

The staff include a full-time executive director; a part-time house manager who coordinates day-time volunteers (9:00 a.m. to 6:00 p.m.), plans lunch menus, and coordinates the volunteer shoppers; a part-time social worker (an MSW so the program can be a site for social work student practicum); a part-time administrative assistant who does grant writing and administrative tasks; and a part-time maintenance person. The program also has two unpaid social work interns who do practicums of 16 hours per week.

The program is heavily dependent upon volunteers. Besides staffing the after-school and weekend programs, two volunteer team leaders come in each night to oversee the church volunteers serve dinner and orient the night team of two to three volunteers who will stay overnight and prepare breakfast.

Barriers and Issues Identified

Staff indicated that the largest barrier to self-sufficiency of the residents is employment that provides adequate income for affordable housing, affordable child care, and health benefits.

Atlanta Community Health Program for the Homeless

Organizational Issues

The Atlanta Community Health Program for the Homeless (ACHPH) began in 1984 as Mercy Mobile Health and offered foot care to homeless people in shelters. The parent organization of ACHPH is Mercy Care Corporation, a subsidiary of Mercy Health Services of the South, which provides special services to Hispanics, homeless people, and senior citizens. The program operated one van, staffed mainly with members of the religious order that founded the hospital at which the program originated. As the project attracted more volunteers, they were able to expand to two vans and regularly provide services to three shelters. In 1987, Mercy Mobile Health was part of a coalition which applied for McKinney funding and became ACHPH. These funds, which were awarded in 1988, constitute most of the direct funding and have allowed the program to expand to more days, more shelters, and a broader range of services. The McKinney funding also allowed the program to subcontract with another coalition member, the Georgia Nurses Foundation (GNF), to support an expansion of GNF's on-site clinic operation. In 1990 the program purchased a 33-foot Health Mobile through a private foundation contribution.

ACHPH also initiated the Atlanta Community Mental Health Care Project, which is a coalition of mental health case managers that meet on a regular basis to discuss and address resource issues and problems, and to strengthen program linkages.

In fiscal year 1990, the Mercy Mobile Health program served 6,939 new clients, and had a total of 12,647 client encounters. About two-thirds of their clients are African-American; almost one-third are male. Family members comprise about 30 percent to 40 percent of the program's clientele.

Points of Entry

The program operates the Health Mobile and three vans which make rounds to shelters, day shelters, and other sites where homeless people are likely to gather. Anyone who presents themselves as homeless can receive services.

The Health Mobile visits 8 to 10 sites per week during the day and additional sites are serviced by the vans. The daytime services are provided by paid staff. On Tuesday through Thursday nights, one van with a health advocate and volunteers provide clinic services at a different shelter each night.

The intake process incorporates an addiction and mental health screening by the social services worker.

Service Delivery

When the program expanded from one to three vans in 1988, it hired health advocates and nurse practitioners to staff the vans. But, because of limited privacy on the vans, many services were referred out. Since purchasing the Health Mobile in 1990, they can diagnose and test for sexually transmitted diseases (STDs), provide prenatal care, offer pap smears and breast health, and perform comprehensive physical examinations.

The program has established a referral arrangement with Southside Community Health Center to provide certain types of care including dental care. Under this arrangement, Southside bills ACHPH for referrals at an agreed-upon rate. ACHPH also has an agreement with Grady Hospital that allows staff to bypass the primary care clinics and refer clients directly to the specialty clinics.

ACHPH also provides extensive case management services for homeless people with mental illness or substance abuse issues. In 1988, ACHPH contracted with Fulton County Health Department to provide two mental health case managers. These case managers were housed with ACHPH but had joint responsibilities and reporting requirements. In 1990, ACHPH obtained funding for a substance abuse case manager and made some changes to their contractual relationship with Fulton County Health Department for the mental health case managers to simplify the arrangement and to provide more stability and better benefits for the staff. Under the new arrangement, Fulton County Health Department contracts with ACHPH to provide mental health case management. The mental health case managers are directly employed by ACHPH, their salaries are partially covered by the Health Department contract, the remainder is covered by ACHPH.

ACHPH case management services focus on short-term, crisis management coupled with advocacy and networking with existing community resources. To meet long-term case management needs, efforts are made to link people to existing case management available through the Fulton and DeKalb County Health Departments and Georgia Mental Health Institute (GMHI). Strong linkages have been built with this program which has given ACHPH access to weekly rounds and a pool of potential clients. ACHPH services also include links to county inpatient and outpatient treatment and, more importantly, to residential aftercare facilities. However, these options are generally not open to women with children because of the lack of accommodations for children in residential facilities.

The program has many established referral links for mental health care, mainly using a network of public resources. For crisis psychiatric care, they can refer to the psychiatric emergency clinic at Grady Hospital for evaluation and stabilization. The case managers work with the State psychiatric hospitals to identify the homeless patients and to assume transitional case management functions before the client leaves the facility for the community. The goal is to facilitate getting the person to the first outpatient mental health center appointment and into initial stable living arrangements.

The program had also received some money for substance abuse treatment, and had experimented briefly with contracting out for services. They concluded that longer-term stable referrals were needed and have developed a fairly complete continuum for substance abuse treatment. The program has an informal arrangement with the county for detoxification and inpatient treatment services. The program now contracts with three recovery residences for 4 to 5 months of recovery treatment. Most recently, the program has worked with one of the recovery residences and a local SRO for a longer program of stable housing and on-site aftercare.

The program has established links with the two county alcoholism treatment centers, and can get patients admitted to their outpatient or inpatient programs and paid for with county money. Upon discharge from the county facility after 28 days, the program has established linkages with several THPs for 2-month transitional programs at reduced rates and is now working with one facility for a longer-term THP. This special program will have a capacity of 24 clients in a phased program of 2 to 6 months inpatient and total of 12 to 18 months of follow-along aftercare in conjunction with a local SRO.

For substance use, the county alcoholism centers are the key relationship since publicly funded inpatient treatment is the most common log-jam in the system. The links to the recovery residences are also key because the availability of the longer-term continuity of recovery treatment is the quid pro quo that entices the county into the informal arrangements for detoxification and inpatient treatment.

In 1989, the program participated in a blind seroprevalence study of homeless people. The incidence of HIV was so high that the program petitioned the State agency to become an unblind testing site. In May 1990, the program received Centers for Disease Control money for STD and HIV street outreach to homeless people. The grant funds four outreach workers who do presentations on risk reduction on the streets and in shelters.

ACHPH is participating in the first demonstration project to test the feasibility of providing modified, nonperishable WIC food packages to WIC participants assessed and certified in the shelter by staff who accompany the Mobile Health team. A nutritionist and a WIC representative have provided on-site assessments, certifications, and vouchers since February 1989.

There is no limit to the duration of service so long as the person is homeless. Staff indicate that tracking client progress is a big problem because once homeless people move on to permanent housing, they lose motivation to pursue health care. The program has also considered expanding the use of the Health Mobile to include public housing projects to respond to the need of low-income people for care.

For substance abuse clients, the program is trying to develop a standardized longer-term program of inpatient treatment, outpatient treatment, transitional housing, case management, and support services which might last as long as 16 to 18 months after treatment.

Coordination and Effectiveness of Services

The staff of the program's vehicles include nurse practitioners, health advocates, and social services staff. Ideally, all staff see each client; however, time usually does not permit that, and the staff generally try to triage the clients so that the social services worker sees those most in need of linkages to outside agencies for substance use or mental health care.

For the mental health services, the case managers work closely with the county and private case workers to develop a plan of community services for people about to be discharged from the State institutions. Case management is according to a discharge plan required by State law; which must include, among other items, a housing placement and a mental health center assignment.

For substance abuse services the case managers track all clients sent for assessment and county detoxification. The case managers arrange for the admission to recovery residences and will determine admission to the longer aftercare programs currently under development.

Effectiveness is defined in process terms rather than in terms of client outcomes. No client outcomes are tracked and the program believes that followup is one of the major gaps.

Financial Issues

The most recent budget included revenues of about $1.5 million. About 60 percent of the program's funding is from public sources. Of this, the majority is from the McKinney grant; the rest includes $310,000 in Federal and State funds to support the AIDS program. ACHPH also receives about $200,000 in-kind general and administrative support from St. Joseph's Hospital.

Although nurse practitioners have been able to bill under Medicaid since 1990 (at 90 percent of the physician rate), the program chooses not to do this because the cost of the billing system required by Medicaid would exceed the revenue brought in.

Staffing

The core staff includes a lab technician, a substance dependence case manager, three health advocates, two nurse practitioners, a service coordinator, a medical director, program director, social services coordinator and a volunteer coordinator.

Fulton County received some additional administrative funding for case managers for mental health and substance abuse clients. These worked as county contract employees and were deployed to the Community Health Care Program. In August 1990, a new arrangement was worked out under which the county contracts with ACHP which then hired the case managers.

The AIDS program includes four outreach workers who do risk reduction presentations, an AIDS coordinator, and two HIV testing personnel. The WIC project has two staff members.

Besides the paid staff, the Mercy Mobile Health Program received 2,871 volunteer hours at a value of $69,425. This includes graduate MSW interns working in the social services department.

Barriers and Issues Identified

Besides improving client tracking, the program would like to examine convalescent care for homeless people who have early discharges from the hospital or from outpatient surgery.

Although the program is committed to use of mainstream services, the reality, in the opinion of staff, is that homeless people who have to access mainstream medical care are forced to choose among labor, food, and health care because of long waits for primary care (staff cite waits of 6 to 8 hours) at public facilities. They also recognize a problem for those who work during evening hours and thus must choose between health care and access to shelters before nightly intake ends.

Accessibility to services for inpatient drug use treatment is a major problem for all homeless people because of capacity constraints. For women with children, the problem is even worse. There are no programs currently available which will allow women to keep their children with them during treatment or recovery. Most homeless women do not have the informal supports to take care of their children while they are away; they fear they will have to give up their children to the foster care system in order to get treatment for their addiction.

Another problem cited by the staff is the 4 to 6 month wait at Grady Hospital for HIV infected persons. In response to this problem, ACHPH has applied for funding under the Ryan White legislation to provide primary HIV care in collaboration with Grady Hospital and Fulton County Health Department.

Other issues mentioned that were specific to chronically mentally ill homeless clients include the following:

- Need for assistance to clients to meet followup appointments (data show that only 26 percent keep appointments) and to become linked to disability income assistance
- Reluctance among shelters to accept referrals from State psychiatric hospitals without active case management support
- Lack of coordination of services and continuity of care
- Lack of identification and services for the mental health/substance abuse dually diagnosed clients.

Homeless Families with Children Program
Department of Family and Children's Services

Organizational Issues

The Homeless Families with Children Program is part of the Department of Family and Children's Services of the State Department of Human Resources. In Georgia, social services are State administered through county-based offices. The Homeless Families with Children Program is funded by the State in several counties. Fulton County has the most extensive and well-developed program.

In 1985 and 1986 when the program operated under a small grant from Fulton County, it had one staff person whose role was to go to the church sponsored night shelters to provide resettlement services to the shelter residents. Resettlement services are broadly defined to include housing search assistance, counseling, and referral. The goal was to link people with affordable housing because, at the time, the housing authority did not accord preference to homeless families. Most of the housing was private because the housing authority has such a long waiting list.

In 1987, the State took over funding, and gave $90,000 to Fulton County and $45,000 to DeKalb County.

Points of Entry

Access to the Homeless Families with Children Program is through the shelter system. Project staff visit the major family shelters and THPs in the county on a regular basis. The intake assessment includes a basic employment history and background and a sense of what clients can accomplish on their own, their skills, and their goals.

Service Delivery

The goal of service delivery is to get the family stably housed and linked to social services in the community. These resettlement services include help with obtaining a social security card or certified birth certificate, providing assistance with the security deposit or first month's rent, and providing basic furniture.

For housing referrals, the staff considers the employment status of the client. Most AFDC mothers are referred to public housing because some housing authorities now give preferences to homeless families and these families need a setting where the housing cost is set at a percentage of income. The staff directs job holders towards private housing.

Besides housing, the staff tries to get the person linked to school, Head Start, and after-school programs. The program has no established links to these services, but is often able to facilitate access by accompanying the client. The community worker also works on life skills such as budgeting and grocery shopping.

The staff has no extra influence to obtain access to public alcoholism and substance abuse facilities, but knowledge of the system facilitates access. In general, the case workers find that the problems start after the mothers are in permanent housing rather than when they are still in the shelter.

Rather than use the county health facilities, staff tend to steer clients to other programs such as Emory University Hospital where Medicaid pays. While mothers have problems finding residential care where they can bring their children, there are a few experimental longer-term child care programs that do not carry the risk of child protective services involvement.

Staff keep most cases open for approximately 1 year. The duration of service has tended to increase; staff attribute this to increased substance abuse problems which interfere with the family's ability to establish stable lives in the new community. Caseloads are currently about 1:50, staff members can follow the families longer, thus enhancing the family's ability to settle in.

Coordination and Effectiveness of Services

Case workers go to the shelters every week to do intakes on new families and to work with the existing families. Since the goal is resettlement, case plans are very similar. Workers do an intake assessment with the family and try to get them linked to services; staff often accompanies them to help facilitate access to services.

Case workers screen all clients for entitlements, often finding people who lack entitlements. The link to AFDC is crucial because it greatly eases the access to public housing. Hence, an important role of the case worker is to expedite paperwork for entitlements.

Effectiveness is defined as the number of families stably "settled in" to housing and social services in their new community. Although the program follows clients for approximately 1 year, the only outcome measure tracked is "satisfactory at time of closure." However, since cases are not closed until they are satisfactory, this presents an unrealistically optimistic evaluation of the program. They also track for loss of contact due to eviction, or referral to child protective services.

The program does track housing placement for clients served each year. In 1989, of 182 families served, 140 families had completed their shelter stays and were placed in housing; about half of these were placed in Atlanta Housing Authority projects, 30 percent in private apartments, and 16 percent in Section 8 housing.

Financial Issues

All employees are State merit system employees. In addition, the State funds the resettlement services out of a separate line item--$90,000 in the most recent fiscal year.

Staffing

The staff just increased in size to three full-time case workers, one full-time community worker, and one full-time social services specialist/supervisor who performs mostly administrative tasks.

Two of the case workers are assigned to the largest county family shelter, and one covers the other smaller shelters.

Barriers and Issues Identified

The largest shelter in the metropolitan area is in DeKalb County not Fulton County. The continuity of social services can be disrupted when clients cross county boundaries for services. Also, the level of resettlement assistance is not as extensive in DeKalb.

Day care is a major gap once women leave the shelter system. Only those in the State's PEACH program (Georgia's version of the Federal JOBS welfare reform program) or involved with programs sponsored by the Private Industry Council (PIC) have access to subsidized day care, and even PEACH is greatly restricting the number of new clients and the services it will provide. A nonprofit organization, Child Care Solutions (part of the Save the Children Fund), offers some limited subsidy day care for women leaving shelters and is trying to attract and train low-income providers of family day care.

Georgia Nurses Foundation
Health Clinics for the Homeless

Organizational Issues

The Georgia Nurses Foundation (GNF) began its Health Clinics for the Homeless Program in 1986 when it opened a clinic adjacent to the largest community kitchen in the city. This clinic serves mainly a single male homeless population. In 1988, McKinney funds channeled through the Atlanta Community Health Care Program for the Homeless (ACHPH) allowed GNF to start a second clinic at the Moreland Avenue Women's Shelter. This shelter serves single women and women with children, and is the largest shelter for families in the metropolitan area.

Points of Entry

The clinic is housed in the same church building as the shelter. Most patients find out about the clinic because they are or were residents of the shelter. Most patients are shelter residents even though the clinic is open to all and is accessible by bus. Staff believe that if homeless people need to use the bus to access care, they are more likely to go directly to Grady Hospital where more services are available.

At intake, the staff takes a brief medical history. Occasionally, DFACS social workers will come to the shelter to see homeless women. They have no connection to the clinic, but only use the waiting room when available.

The clinic opens in the late afternoon before the shelter opens and serves all homeless people, not just shelter residents. The clinic is not bound by the shelter's eligibility restrictions and can accept men and older male youth as patients. All people who present themselves as homeless receive service.

Service Delivery

The clinic is staffed with nurse practitioners. They can handle most routine care and administer immunizations, skin care, TB tests, and flu shots, and can dispense medication according to written medical protocols. Recently, the clinic began doing gynecological work, including Pap smears, pregnancy tests, and STD tests.

Medical backup is provided through the Department of Community Health at Morehouse School of Medicine. A physician in the department spends time at the clinic. Also, residents are on call on a rotating basis as part of their medical training in community medicine. During their on-call periods, they must spend 3 hours per week at the clinic, review cases for which they have been consulted, and do medical backup.

Lab tests are processed at the DeKalb County Health Department central facility.

Referrals are made to one of several places. The GNF has some established links to a private dentist for routine teeth cleaning. Southside Community Health Center has grant funding to provide eye care, primary care, and some dental care.

A major referral link is the DeKalb County Health Department clinic in the nearby Kirkwood neighborhood which can accommodate gynecological and pediatric care, and perform physicals. Grady Hospital offers specialty clinics in all areas.

The clinic purchases MARTA tokens for patient transportation to referrals and also has one-way taxi vouchers for immediate transportation to Grady Hospital.

The GNF refers those with mental health or substance use problems to mainstream services. It has no established referral links for substance use, but does have referral arrangements for mental health care with Grady Hospital and DeKalb County Health Department.

There is no limit on the duration of service; however, patients tend to lose contact with the clinic once they leave the shelter--usually in 90 days or less.

Coordination and Effectiveness of Services

There appears to be little case management of health care because homeless people may be using a variety of health care providers including the ACHPH Health Mobile and community providers as well as the GNF clinic. It is hard to coordinate these multiple interactions and to avoid duplicating services.

Followup is hard to do unless the patient continues to receive care at the clinic after leaving the shelter. Patients do not typically leave forwarding addresses. Staff do retain the medical charts, and sometimes get calls from the next provider, but not often.

Effectiveness is defined in terms of process goals such as efficiency. Client outcomes are not being tracked and would be hard to track given the sporadic nature of client contact and the multiple providers with whom an individual client may be involved.

Financial Issues

The clinic's major source of funding is McKinney money channeled through the ACHPH. Patients pay no charges for clinic services. Care at Southside is provided free of charge under a grant; Grady provides free care for 3 months with a GNF clinic referral.

The shelter social workers help patients obtain entitlements such as Medicaid, which pays for most care at Grady.

Staffing

The clinic is staffed with two part-time nurse practitioners and one full-time clinic assistant. Relief nurse practitioners are hired on a per diem basis when one of the staff nurse practitioners is unable to work.

Besides the paid staff, Morehouse residents put in 3 hours per week on a rotating basis and volunteers (nurses and others) assist the nurse practitioners and clinic assistant in both clinical (direct client care) and nonclinical tasks.

Barriers and Issues Identified

Staff indicated that the major gap is obstetric and prenatal care. With more support from the obstetric community, they would like to provide prenatal care via nurse-midwives. Currently, pregnant women are sent to Grady or two other clinics. The staff also would like to provide family planning services.

Chapter II

Site Visit Report

Baltimore, Maryland

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Chapter II. Site Visit Report--Baltimore

I. Introduction

The study team selected Baltimore for a site visit largely because of the existence of several innovative projects linking social services to housing in the public housing system. The study team was interested in learning if this model had been extended to include homeless families, and, if not, the applicability of the model to homeless services. The study team was also aware of several innovative programs within the homeless service system, including a provider coalition dedicated to homeless family and children's issues, the only one identified among the five cities visited.

II. Overview of Site Visit

The Macro study team visited Baltimore on October 30, 31, and November 1, 1990, to explore how the city's existing programs and service delivery system were meeting the needs of homeless families with children. During the visit, the study team interviewed many of the key players in Baltimore's service system for homeless families. They included representatives of State and local government agencies, advocacy groups, and service programs. Their organizations are also involved in program activities; where possible, the study team toured the program facilities.

The following officials from State and city government offices were interviewed about their involvement in the delivery of services for homeless families with children:

- Housing Authority of Baltimore City
- McKinney Education Coordinator, State Department of Education
- City of Baltimore, Mayor's Office of Homeless Services
- Former Commissioner, Neighborhood Progress Administration[1]
- Emergency Environmental Services Unit, Baltimore City Department of Social Services
- Housing Unit, Division of Families and Children, Baltimore City Department of Social Services

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[1] In early 1988, after municipal elections, the Neighborhood Progress Administration was split into two agencies: the Department of Housing and Community Development (HCD) and the Office of Employment Development (OED). The OED currently has the administrative responsibility for the Family Development Center.

The study team also interviewed program staff and visited the following programs and program components that serve homeless families:

- The YWCA of Greater Baltimore
    - Eleanor D. Corner Emergency Shelter
    - PACT Therapeutic Day Care Center
- Coalition for Homeless Children and Families
    - Family Mentor Program of the Baltimore Homeless Families Program
- Housing Authority of Baltimore City
    - Family Development Center at Lafayette Homes
    - Family Support Center at Lexington Homes
- Family Start Program, a comprehensive child development center for at-risk children, funded by Head Start
- The Ark Day Care Center, a day care program specifically for homeless children
- Health Care for the Homeless Project
- Transitional Housing Program (Springhill and Rutland Apartments)

The purpose of these discussions and tours was fourfold: (1) to gain a general understanding of the size and scope of the problem of family homelessness in Baltimore, (2) to outline the service delivery system in the city as it serves these families, (3) to describe innovative service programs, and to (4) identify issues and barriers preventing homeless families in Baltimore from gaining access to services they need.

In addition, the study team interviewed the coordinator of the Coalition for Homeless Children and Families, an association of service providers, advocacy groups, and government agencies that is working specifically to address the issue of homeless children and families.

Exhibit 1 is a table which describes the interview participants for this site visit. Exhibit 2 is a flow diagram which depicts the interrelationships of the major components of the service system for homeless families in Baltimore. Profiles of the programs visited are attached in the appendix. These represent selected examples of some of the programs that comprise the service delivery system in Baltimore.

III. Contextual Issues

As in cities and counties across the nation, there is no single factor responsible for family homelessness in Baltimore. Rather, many factors appear to be working together to increase the risk that an individual or family will become homeless.

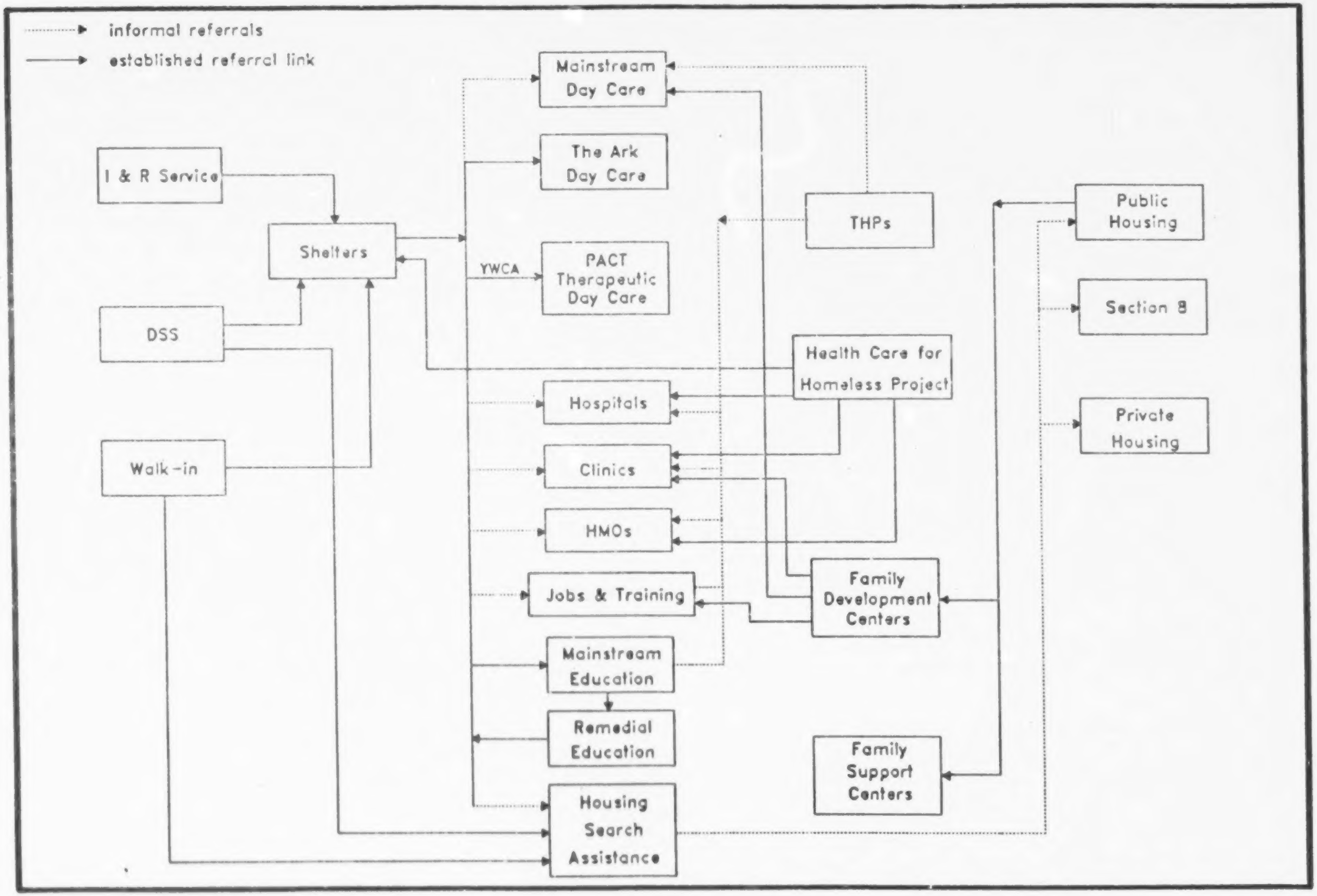
EXHIBIT 1

DESCRIPTION OF SITE VISIT PARTICIPANTS: BALTIMORE

Program Name	Organization Type	Services	Toured Facility
The Ark Child Care Center	Child Care Center	Dedicated child care for homeless mothers and with children	X
Health Care for the Homeless Project	Health Program	Provision of health services, training of mainstream providers, advocacy on health issues	X
Elizabeth Corner Shelter, Baltimore YWCA	Shelter	Emergency shelter and services for homeless women with children, therapeutic child care center	X
Family Start Program	Child/Family Development	Comprehensive child care and family support services	X
Transitional Housing Program, Inc.	Transitional Housing Program	Transitional housing and services for homeless families with children	X
Mayor's Office of Homeless Services	City Office	Oversight of city's efforts in homelessness, coordination among city agencies	
McKinney Education Coordinator, State Department of Education	State Office	Oversight of access and choice provisions of McKinney Act	
Public Housing Authority, City of Baltimore	City Office	Oversight of Family Development Center and Family Support Centers in public housing projects	X
Neighborhood Progress Administration, City of Baltimore	City Office	Planning and operation of public housing programs and neighborhood development programs	
Environmental Services Unit, State Department of Social Services	State Office	Oversight of social services and Project Independence (JOBS) program	
Housing Unit, Division of Families and Children, State Department of Social Services	State Office	Crisis housing services for homeless families	

EXHIBIT 2

FLOW OF CLIENTS THROUGH THE SERVICE SYSTEM: BALTIMORE


informal referrals
established referral link
Mainstream Day Care
The Ark Day Care
I & R Service
THPs
Public Housing
Shelters
YWCA
PACT Therapeutic Day Care
Section 8
DSS
Health Care for Homeless Project
Hospitals
Private Housing
Walk-in
Clinics
HMOs
Jobs & Training
Family Development Centers
Mainstream Education
Remedial Education
Family Support Centers
Housing Search Assistance

Approaches to addressing the issues presented by family homelessness are heavily influenced by the social, political, and economic environment. This next section describes the characteristics of the homeless family population, some of the factors related to causes of family homelessness, when and how a response to the problem took shape, and the political and social climate in Baltimore.

A. Size and Characteristics of the Population

Since 1986, the State of Maryland has been required by the legislature to collect data on homelessness in the State. As measured by the numbers of individuals using or seeking shelter, the State experienced a dramatic increase in homelessness between 1986 and 1990. Each year more individuals used or sought shelter. In 1989, in Baltimore alone, a total of 21,658 individuals were served in emergency shelter programs and another 592 were served in motels. More than three-quarters of shelter users were male. African-Americans constituted 74 percent of shelter users.

This and other shelter surveys describe the homeless population as diverse. It includes ill individuals, pregnant teens, young women with children, unemployed and underemployed men and women, and individuals with substance abuse problems.

Family homelessness appears to be increasing as a percentage of the homeless population. In fiscal year 1989, family members comprised 20 percent of the homeless in Baltimore. While the numbers of family homeless are increasing, some assert that they do not accurately represent the size of the homeless population, but instead reflect the relative ease of opening shelters for families rather than for single men, the largest component of the homeless population.

The problems experienced by homeless families in Baltimore have not been measured in detail, but have been attested to by shelter providers. Shelter providers interviewed for this study describe a typical homeless family as a single African-American mother in her mid-twenties with two to three children. Intact families have not been a major component of the homeless population, although several providers believe their numbers were increasing. The director of a major shelter for homeless families indicated that few homeless women with children are employed. Those few women who enter shelter with jobs often find that lack of child care and transportation services make it very difficult to continue to hold a job.

B. Factors Related to Family Homelessness

Economic or Structural. Baltimore enjoyed an economic boom for most of the 1980s, although like most cities, Baltimore experienced a shift from manufacturing to service jobs. Recently, the city's economic situation has deteriorated. Anecdotal information from the Baltimore Department of Social Services indicates that AFDC caseloads have grown rapidly over the last year, especially among homeless and other low-income families. In FY 1990, the State suffered its first overall budget deficit and the first deficit in its human resources budget in several years. Baltimore, which has always been strapped for money, sent the message to the provider community that there was little support available for homeless services.

Baltimore shares many of the problems of older East Coast cities. First, the core population is poor. More than one-quarter of Baltimore's households are below the poverty line, and an additional 20 percent live on less than $10,000 per year. Second, its housing stock is old and deteriorating. This makes expanding the number of Section 8 housing units difficult and is a factor in Baltimore's high number of evictions.

Third, while evictions are a major factor in family homelessness in the city, service providers believe that an even greater problem is the number of families who are doubled- or tripled-up in inadequate housing situations. Housing is expensive. Although Baltimore is widely reputed to be less expensive than surrounding areas, such as the District of Columbia, homeless advocates feel that affordable housing is drying up, due to downtown development, gentrification, and most importantly, because of the deterioration in the housing stock.

Service providers also point to inadequate levels of public assistance as a factor in family homelessness. Although AFDC coverage in Maryland provides some benefits at earned incomes up to 150 percent of the poverty level, advocates feel that the monthly benefit is inadequate to support affordable housing. Average rent for a one-bedroom apartment in the city is $325 per month which would consume 80 percent of the monthly AFDC grant for a family of three, and subsidized or public housing assistance is considered to be in short supply. In discussions with advocates, providers, and government representatives, the shortage of Section 8 certificates was brought up numerous times. In addition, waiting lists for public housing are very long. When vacancies exist, they are often in the least desirable projects; because young, female-headed families often have few other options, they end up in the high-rise, most crime- and drug-filled projects.

Advocates and others pointed to some bright signs in Baltimore's housing assistance and social service programs. Transitional housing programs appear to receive preferential access to Section 8 housing and other public housing programs. In addition, the city's Department of Housing and Community Development has initiated a Housing Relocation Office that works with private and public landlords to identify affordable housing. Finally, there are a limited number of vouchers for hotels and motels available to families, although these are used mainly for families that cannot be accepted in shelters, such as large families, those with a child or family member who is sick or has chronic mental illness or behavior problems.

Individual Factors. As in most cities, advocates and service providers are sensitive to the implication that homeless individuals are different than low-income individuals in general or that individual issues contributed to their homelessness. In Baltimore, most see homelessness as a structural failure and believe that the solution in terms of services is to improve the service delivery system so that it better accommodates homeless individuals. Nevertheless, most informants recognize that individual factors, whether or not they are the cause of homelessness, plague most low-income individuals and families and hinder economic self-sufficiency. Estimates of the percentage of homeless in Baltimore with individual factors confounding their homelessness varied from provider to provider. All were aware that Baltimore leads the Nation in teen pregnancies. Many indicated that a large number of homeless families have been victims of abuse, are undereducated, and abuse drugs. Drug use, particularly crack use, has increased in the downtown Baltimore area. Staff at the Transitional Housing Program indicated that about one-third of all applicants to the program are actively using drugs, a marked increase from the past.

C. Development of a Response to the Problem of Homeless Families

Several aspects of Baltimore's political structure affected the development of the city's response to the problem of homelessness and the more recent problem of homeless families with children. They are (1) the political jurisdiction of the city, (2) historical consolidation of key housing and social services agencies, (3) a widely held holistic philosophy towards serving at-risk families, (4) a city-level office for homeless services, and (5) a strong, nonprofit shelter network and active voluntary sector.

Political Jurisdiction. While most large cities are embedded in geographically larger counties that encompass both the city and its suburbs, the city of Baltimore exists as a separate political entity equivalent to a county. Having its own political jurisdiction offers Baltimore an advantage over cities that have both city and county jurisdictions; in Baltimore, a layer of government bureaucracy is removed. Theoretically, Baltimore has a better chance of coordinating services for homeless families because one level of government--the county--is removed as a key player in decisionmaking. On the other hand, a disadvantage of Baltimore's being a separate political jurisdiction is that it is also a separate tax-raising entity and, as such, has access to a smaller revenue base than most cities that are embedded in counties. Baltimore's tax base suffers inordinately from problems such as urban flight to the outlying suburbs because there is no basis for revenue sharing with the surrounding county.

Consolidation of Key Service Agencies. In the early 1980s, when Federal funding for new public housing construction was terminated and operating subsidies were reduced, Baltimore, like many other cities across the country, experienced a serious shortage of low income housing. At this point, many low-income families in Baltimore were locked into high-rise public housing settings with little or no prospect of ever getting out. In 1984, the city consolidated the Housing Department, the Housing Authority, and the Office of Employment Development (OED) into one large public agency, the Neighborhood Progress Administration (NPA). As a result, NPA administered the public housing and community and urban development programs, as well as a citywide AFDC welfare reform initiative and the employment and training system.

By having multiple funding sources flowing through one administrative entity, the potential for integrating services for low-income families in Baltimore was greatly facilitated. In 1986, the NPA, motivated by a desire to act as more than a landlord to low-income housing residents, decided to experiment on ways to address the needs of these residents in a more holistic manner. The result of this experimentation was the creation of two types of integrated service delivery centers in selected high-rise public housing in Baltimore, a Family Development Center and several Family Support Centers. The consolidation also encouraged Baltimore to combine its JOBS and JTPA welfare reform programs for AFDC clients into one integrated approach called Project Independence. As a result, Department of Social Services and OED resources are coordinated for participating families.

Although OED is now a separate department, the continued merger of the Housing Department and the Housing Authority allows for a more holistic approach to housing and neighborhood development than exists in most cities where the Housing Authority has more of a "landlord" responsibility, and the planning and operations functions are totally unrelated organizationally.

Attention to services for at-risk families. The holistic philosophy that was integral to the design of the Family Development Center and Family Support Centers in high-rise public housing is shared by many other service providers in the Baltimore service delivery system. In the site visit discussions, providers were adamant that very little distinguishes homeless individuals and families from poor families in the city; before becoming homeless, homeless individuals and families were tenuously housed as are many of Baltimore's poor residents. This philosophy in which homeless families are viewed as the worst off on a continuum of at-risk families has led government officials, advocates, and service providers working with the homeless to focus on addressing poverty as the root cause of homelessness.

This philosophy is evident in many service initiatives in the city. For example, the city's Health Care for the Homeless Project's goal is to link the homeless to the mainstream health and human service system, if at all possible. The Family Start Program, a comprehensive program for children ages 0-5 years, views itself as a homelessness prevention effort; families served by the project are considered to be one step away from being homeless and in need of comprehensive services to prevent their falling further through the social services safety net. This program views the problems of at-risk children within the context of their families and, even more broadly, within the context of their neighborhoods. Program activities reflect this holistic view of helping at-risk children. Finally, the Mayor's Office of Homeless Services reported that its goal is to improve the mainstream service delivery system in Baltimore so there is no need for a separate delivery system for homeless individuals or families. Although the director of the office recognized that those few shelters providing comprehensive services to families are filling a great need, the mayor's office sees the need for such services as a failure of the mainstream service delivery system. A better, long-term approach to the problem would be to provide these services in a centralized fashion that would make better use of limited resources and potentially affect more homeless families.

Mayor's Office of Homeless Services. Baltimore's involvement in homeless issues has been centralized under the current mayor into the Mayor's Office of Homeless Services. Since its creation in 1985, the office has provided leadership in the city in the areas of planning and coordinating services for the homeless. Although the office provides no direct services, it acts as a forum and a liaison among city agencies and between the city and the provider/advocate community. For example, the office provides staff to the Mayor's Interagency Coordinating Council on Homelessness, which includes key city agencies and the State Department of Social Services, and acts as the city representative in discussions with homeless service providers and advocates. In its planning role, the office performs an ongoing needs assessment for various segments of the homeless population, recommends city policies and new programs to meet identified needs, and assesses the impact of current resources for the homeless.

The office appears to be a key factor in the generally cordial relationship between the city government and service providers and advocates. The office took the lead in developing the city's response to the request for proposals for the Homeless Families Program funded by the Robert Wood Johnson Foundation, and the current director of the office is a former provider and activist who is widely respected.

Strong, active voluntary sector. The culture and climate among homeless advocates and service providers in Baltimore is very cooperative. Throughout the site visit discussions, informants described the nonprofit shelter network as particularly strong. Data collected by the Mayor's Office of Homeless Services bear out the key role the voluntary sector plays. Out of a $10 million budget for direct homeless services (including annual operating costs and capital costs), 40 percent is from private sources, 15 percent from Federal sources, 30 percent from State sources, and 15 percent from city sources. And, these figures do not include the value of volunteer services. At the same time, studies indicate that Baltimore fares poorly in corporate and foundation philanthropy in comparison with other major cities.

D. Political and Social Climate

The current political and social climate for serving homeless families in Baltimore is affected positively by many of the factors discussed above such as the strong provider community and the existence of the Mayor's Office of Homeless Services. Many other factors influence the development of services in the city. The financial climate is a key factor. In general, Baltimore has fared well in securing Federal and foundation demonstration grants for homeless individuals and families. However, many of these grants have been secured for innovations in the public housing system rather than for direct homeless services. The exceptions are the Health Care for the Homeless Project grant, which secured funding several years ago through the Robert Wood Johnson Foundation and now through Federal McKinney/HHS monies; the Federal McKinney/HUD grants that help support the Transitional Housing Program, the city's largest THP for homeless families; and the new Robert Wood Johnson Foundation grant for the Homeless Families Program, one of nine demonstration programs funded in the Nation on this topic.

Several informants indicated that private sector trust in the public sector is strong in Baltimore. As evidence, these informants cite the large donations from a private developer that helped create the Transitional Housing Program. However, the role of the private for-profit sector in funding homeless services is not obvious; most programs appear to rely heavily on grant funding from large national foundations rather than local sources.

Service programs in Baltimore face a continual dilemma of how to obtain funding to operate their programs. The city government provides no direct services to homeless families other than through the general social services system for all low-income people, but does issue grants to shelter providers. The State is now facing a budget deficit after years of surpluses.

The city is in worse shape. Although there has been a business boom in the downtown harbor area, the city has been hurt by urban flight to the outlying suburbs; census counts indicate that the city population has declined dramatically. At the same time, the poverty rate in the city is over 20 percent. The current city financial situation was described by several informants as serious: the citizenry is in greater need, yet the city has no additional resources to address these needs.

IV. System Coordination Efforts

Baltimore has a number of system initiatives at the agency, provider, and individual family level that contribute to the coordination of services to homeless families with children.

A. Coordination Efforts at the Agency Level

As discussed earlier, Baltimore has been able to coordinate agency funding to an unusual degree in some of its housing/employment and training efforts. A key example is Project Independence, which will combine resources of the Department of Social Services (a State agency) and the Office of Employment Development (a city agency). The Family Development Center/Family Support Center concept in public housing is also an example of how multiple agencies have worked together on demonstration projects to create comprehensive programs to help low-income families achieve economic self-sufficiency. In operation, these centers involve staff from the Office of Employment Development and other agencies providing services in Housing Authority space.

With the exception of the normal links between income maintenance and medical assistance, the study team saw no special examples of coordinated eligibility for programs. Although many programs for homeless families referred families to public assistance offices for eligibility screening, there were no system efforts to link eligibility beyond that already provided for in national policy.

B. Coordination Efforts at the Provider Level

Coordination Philosophy. Baltimore's service philosophy is based on the idea of coordination; it is widely held among advocates and service providers that services for the homeless should be in the mainstream system rather than in a dedicated system. Service providers describe the homeless as low-income individuals who cycle in and out of homelessness; many initiatives target tenuously housed families or otherwise at-risk families in order to prevent their entry or reentry into homelessness. Because of its mainstream service delivery system focus, Baltimore has, to a certain extent, avoided creating a duplicative service system for the homeless. However, this philosophy requires key players in the service system to take a longer-term perspective on homelessness. Because the short-run needs of homeless families have been great and services scarce, some programs that specifically target homeless families, such as child care, have developed outside the mainstream system.

Coordination Vehicles. Baltimore has both informal and formal vehicles for service collaboration among homeless service providers. In general, these efforts reflect the high levels of cooperation and coordination that exist among providers. It was suggested that part of the reason that the informal network works so well is that it is made up, in part, of a tight core of homeless advocates who have moved from agency to agency or from program to program working on the homeless issue.

Direct service delivery coordination occurs mostly on an informal basis. One example of this type of coordination is the informal information and referral system shelter providers use to help individuals and families to locate shelter space. This information and referral system allows homeless families to ascertain which shelters, among those participating, will accept them and if shelter space is available on a particular day. However, because the intake system is not computerized, information is entered on a sporadic basis and a family may very easily arrive at a shelter and find it full.

A significant example of a formal coordination effort is the Coalition for Homeless Families and Children. In the spring of 1989, a local advocacy organization brought together interested shelters and agencies to address the service needs of homeless children and families. Most of the representatives were particularly interested in addressing the lack of child care for children in shelters. The coalition's accomplishments in the year and a half that it has existed have been significant. It has helped develop two day care programs for homeless preschoolers, a summer day camp for homeless children, children's services within transitional housing, and follow-up services for homeless families leaving shelters. More important, the coalition has been able to leverage more than $460,000 from public and private sources to fund these programs.

The coalition has also played a major role helping the key players in the government and nonprofit sector work together more effectively. With the Mayor's Office of Homeless Services, the coalition has assisted in grant-writing efforts for homeless families. The YWCA of Greater Baltimore, the coordinator of the coalition, will be responsible for a key portion of the new Robert Wood Johnson Homeless Families Program that the Mayor's office will administer. The coalition has also been successful at redirecting turf battles among shelter and other service providers into a common effort. Several instances were pointed out in which coalition members helped write grants for money that other agencies would receive or where many agencies were coordinating different pieces of a larger whole. Perhaps even more unusual, service providers often decide among themselves who is in the best position to provide a particular service and consequently receive the program funding. In this way, providers reduced competition for limited resources.

C. Coordination Efforts at the Family Level

Although the informal provider network works well in many ways, it has not been effective in tracking or following up with homeless families once they leave a particular program.

Informants were very vocal about the absence of case planning and follow-up services for families in the emergency shelter system. No one player in the system acts as a "hub" to coordinate services. For the most part, family case management falls to each individual provider, and each provider's ability to offer comprehensive services depends on the particular provider's budget constraints and the amount of time the client spends in the program.

There are, however, a number of current and future initiatives in the city that help homeless families or tenuously housed families receive the housing and social services they need. An example of a cross-program effort is the shelter information and referral network. Within individual programs, the study team identified several comprehensive program efforts for homeless families. The YWCA of Greater Baltimore Eleanor D. Corner Emergency Shelter is one of only a few shelters that provide comprehensive services for homeless families. In addition to offering 24-hour shelter, the YWCA offers therapeutic day care for preschoolers, case management services for families, and after-school tutoring for school age children. The Transitional Housing Program, which provides longer term shelter and support services for homeless individuals and families at two sites, offers families a range of services including job training, academic counseling, family life skills training, day care, and parenting classes. Finally, within two high-rise public housing projects, Lafayette Courts and Lexington Terrace, where the overwhelming majority of residents receive public assistance, the city agencies and others have developed integrated service delivery centers. These centers, called Family Development Centers and Family Support Centers respectively, offer families employment and training services, remedial education, and family support services such as child care. In some communities they would be called "one stop shopping service centers."

Site visit informants expected family-level coordination of services to improve in the near future when the recently funded Robert Wood Johnson Homeless Families Project gets underway. The main goal of this effort is to create an infrastructure in the service delivery system to allow for more continuity of care for homeless families. The Baltimore project will employ family mentors, who are trained community members, to assist families in their transition from emergency shelters to public housing. In addition, case managers will ensure that participating families get access to the services they need for a period of up to 2 years or until the family is able to live independently. This project will assist approximately 190 homeless families; however, some of the service initiatives are expected to spill over to nonparticipating homeless families as well.

V. System Comprehensiveness

This section presents the service system components and discusses how each addresses the needs of homeless families, describing the primary service providers or actors, and how services are provided, noting their comprehensiveness, capacity, and barriers and gaps in service delivery. It should be noted that the following comments are general impressions based on interviews with a limited number of government agency representatives, service providers, and advocates.

A. Housing Continuum for Homeless Families

Emergency Shelter. There are 52 homeless facilities in Baltimore with a capacity of 1,519 beds--including 319 winter-only beds. Of the 1,200 year-round beds, 70 percent are emergency shelter beds and 30 percent are transitional housing program spaces. Baltimore has 10 emergency shelters for homeless families with children. All but a few of the shelters operate year-round and all but four are open 24-hours per day. Shelter programs vary widely in quality, scope of services, and duration of stay. Some allow only 21-day lengths of stay, whereas others are considerably longer; for example, the YWCA shelter which allows a 13-week length of stay.

Shelter undercapacity is an increasing problem. In FY 1989, 24,632 requests for shelter in Baltimore could not be accommodated. It is not known how many of these were families with children; however, providers at the YWCA indicated that they turn away 400 to 500 people each year.

There is no central intake system for emergency shelters; there is, however, an informal information and referral system. Clients find their way to shelters by calling this information and referral hotline, on their own, through the Department of Social Services (DSS) referral or through Travelers Aid. If a client requests shelter but the shelter is full, the client will be referred to another shelter program. DSS runs a housing crisis intervention office that contracts for a limited number of beds (15) at the Salvation Army 30-day shelter and has a limited number of vouchers for hotels/motels and for overnight shelters.

Transitional Housing Programs (THP). The housing continuum in Baltimore includes five transitional programs. The term "transitional" when applied to housing in Baltimore appears to distinguish only duration of stay. It designates shelter spaces that permit occupants to stay more than 13 weeks--the maximum length of stay for emergency shelter designation. As a result, theoretically and actually, some of the better emergency shelters offer more services than some of the transitional programs.

Of the five transitional housing programs serving families with children in Baltimore, the Transitional Housing Program is the key service provider and comes closest to the common use of the term "transitional" to designate second-stage housing with intensive services. It offers multi-year program participation, fairly comprehensive services on-site, and good referral links to off-site services.

There are no formal linkages between the emergency shelters and transitional housing programs. Staff at the YWCA shelter indicated that they attempt to refer clients to one of the transitional programs, but openings are sporadic.

No services-enriched housing models for homeless families were identified during the site visit. Indeed, the Transitional Housing Program had been offered the opportunity to run such a program and opted not to. Although the Family Development Center and the Family Support Centers in the housing projects and low-income neighborhoods are models of services-enriched housing, homeless families do not access them widely.

Permanent Housing. Permanent housing opportunities include public housing, Section 8, and private housing. The city's Department of Housing and Community Development has initiated a new Housing Relocation Office with several counselors who help identify private and public affordable housing. Housing counseling is offered by most of the larger shelter programs. While opportunities appear plentiful on paper, many informants indicated that affordable housing was the major problem for homeless families.

Vacancy rates are very low in public housing except in the high-rises, the least desirable locations with the worst living environments. Waiting lists for public housing and Section 8 housing are very long. However, homeless families receive some prioritization for both, including participants in transitional housing programs such as THP.

Because of the lack of affordable housing, families leaving shelters often move into tenuous housing situations. Some providers indicated that many go back to the doubled-up housing situations from which they came, for lack of better alternatives. Some site visit informants indicated that some homeless people from doubled-up situations enter the shelter system voluntarily, thinking they might improve their chances of gaining access to public housing. However, no data are available to document this.

The study team identified no landlord mediation services. This is an important gap given Baltimore's high number of evictions.

B. Developmental and Health Services

Developmental Services. Developmental screening and intervention is made available by selected programs. The site visit team spent considerable time with the staff of Family Start, a new demonstration program operating in two low-income neighborhoods. The program is one of several Federally-funded Comprehensive Child Development Projects around the Nation which are being operated through Head Start. The family is the focus of intervention, and participants are identified who are pregnant or have a child less than 6 months old. The program will work with the family for 5 years--until the child enters the school system. Services are multi-faceted but include, at the core, a "Family Friend" who works closely with the family on infant stimulation and parenting skills. In addition to Family Start, the YWCA shelter's PACT program--a therapeutic nursery program for mothers--and The Ark Day Care Center for homeless children, will also be providing developmental interventions.

Health Services. Medical assistance coverage in Maryland appears to be liberal and is accessed through General Public Assistance (GPA) and AFDC. AFDC eligibility is extended to two-parent families where one partner is unemployed or disabled as well as to one-parent families. There is pressure to enroll all medical assistance clients in an HMO. This presents problems for homeless providers because transient homeless people often move out of the catchment area of the HMO. Accessing services from another provider is usually permitted only in an emergency and still may entail time-consuming clearances from the host HMO and depend upon the gatekeeper's definition of "emergency." Also, the extent of mental health coverage varies from HMO to HMO and some gatekeepers have very different definitions of mental illness than do service providers. Medical assistance no longer covers transportation, which makes the HMO problem more difficult for shelter providers who must transport a client to his/her HMO clinic for service.

Most shelter providers and public housing officials indicated good referral relationships for medical care. Most were using the emergency and ambulatory clinics at the closest medical centers and felt that a semi-formal referral arrangement minimized the problem of access and waiting times. However, there are concerns about mothers who miss appointments because of lack of motivation, scheduling problems, or more immediate concerns. This tends to reinforce providers' negative views of homeless people and makes them more reluctant to go out of their way to provide access.

Baltimore is the recipient of a Health Care for the Homeless (HCH) Grant. For those not eligible for medical assistance or an HMO, the HCH clinic is the provider of last resort. However, HCH staff believe that many persons who are eligible for medical assistance are still opting to come to the HCH clinic because they have an established relationship and are treated more humanely. HCH is working hard to screen all patients for medical assistance eligibility and to submit for reimbursement for covered services. HCH does extensive training of shelter workers, case finding, and developmental screening at shelters. Their focus is to make linkages to the mainstream health care system whenever possible.

HCH informants reported that the problem in Baltimore is not availability of services, but getting the system to assume responsibility for homeless people as clients. Community health centers have a reputation for being unwelcoming to homeless clients.

The requirement for updated immunization records for enrollment in day care and school has lead to the discovery of gaps in immunizations among homeless children. To address this problem, shelter providers are making linkages to the city public health clinic system's special immunization clinics. Some schools are getting involved in EPSDT screening; however, it is unclear whether this is on a school-by-school basis or a coordinated policy.

Prenatal care is provided by referral to the medical center clinics. HCH refers most frequently to the Mercy Hospital Clinic. Besides referring to the mainstream system for teens, HCH maintains good links with two shelters that specialize in teens and also has some links to physicians and clinics that will treat teens.

Although Baltimore has not emphasized onsite health services at shelters, HCH and others do run screening clinics. The city health department also staffs a clinic at Lafayette Homes which does EPSDT screenings and check-ups, and makes referrals to other providers. This service is open to residents of Lafayette Homes and is offered in the Family Development Center in space provided by the Housing Authority.

C. Education

Preschool. Although Head Start targets services to preschool age low-income children, it is not a widely used service among the homeless. Access is limited by waiting lists and by the fact that most Head Start programs are only half-day programs, and homeless families typically need full-day programs for their preschool age children.

There are no dedicated Head Start programs in Baltimore serving homeless children and families. Several providers reported that they have considered starting a Head Start program for homeless children, but these efforts have not been pursued due to physical facility and other limitations. Parents in the Transitional Housing Program seem to be more successful at gaining access to Head Start than are shelter parents, probably because THP parents' longer length of stay allows them more time to find a program and decreases the pressure to look for housing and employment on a full-time basis.

School-Age. The State and local school districts have made a strong commitment to providing mainstream eduction for homeless children. The Department of Education has an active McKinney coordinator who has put into place a comprehensive tracking system that provides unduplicated counts of homeless children enrolled in and attending public schools. Data from the tracking system indicates that there were 2,095 sheltered children between 1988 and 1989--1,381 of these were school-age children. One-third of homeless school-age children were not attending school two years earlier. That percentage has since been reduced to 21 percent, attributed primarily to the provision of transportation as well as advocacy efforts that have heightened the awareness of homelessness among the school districts.

The process of ensuring that children in shelters attend school has faced some barriers. Some of these barriers have been overcome and others have not. The State does not reimburse for transportation to schools outside of a family's home district. This created a barrier for homeless children in shelters whose school of origin was in another district. The City of Baltimore school district responded to this problem by providing special transportation services so that all homeless children could stay in the same school for the full school year. The city uses the existing bus routes where possible, but must resort to taxis in many cases. The schools have been aggressive in providing resource centers at shelters to encourage mothers to enroll children, and for the most part, systems barriers to enrollment at the school of origin have been removed. The remaining barriers now appear to be personal or attitudinal. Many parents are uncomfortable having their children leave them during the crisis of homelessness. Families usually believe that their situation will be short-term and that soon, when they leave the shelter, children will be back at school. Consequently, these parents may fail to complete the paperwork necessary to receive services. Also, the lack of before- and after-school child care makes it difficult for parents to hold a job or to conduct a job search within the school schedule.

The site visit team found several other ongoing activities related to the education of homeless children. "School Days" is a statewide drive within schools to collect donations for school supplies for homeless children. These supplies are distributed through the shelter system to avoid stigmatizing the recipient children. Some shelters also have small funds to pay for school supplies and other sundries. In addition, the site team learned that the McKinney Coordinator tries to advise shelters and other advocates of the assessment dates for special programs for gifted or handicapped children. However, the timing of application cycles and waiting periods for appointments were identified as major obstacles to access to programs by transient homeless families. The McKinney Coordinator has worked with the Special Education Office to reduce the 30-day turnaround time for assessments to help make these programs more accessible.

After-School. Advocates have resisted transitional classrooms or other designated services for homeless children. They have opted instead for tutoring and remediation outside of school. The State Department of Education's "Helping Hands" program provides after-school tutoring and activities 4 days per week in 18 sites (9 in Baltimore) tied to shelters. In addition to Helping Hands, several tutoring programs are offered by individual programs such as the Transitional Housing Program in conjunction with local colleges and professional organizations.

D. Child Care

The main avenue of access to mainstream affordable day care for homeless families--and low-income families--is through vouchers for DSS subsidy. Although shelter providers are well-informed about day care options and can refer mothers to day care, successfully obtaining it depends on the mother's perseverance and the availability of DSS subsidy. Homeless children are considered a priority group for the subsidy, but higher priority is given to children under Child Protective Services (CPS) and persons enrolled in the Project Independence welfare reform program. A current freeze on additional DSS-subsidized slots has made the situation even worse.

Homeless mothers have several day care options while they are in shelters. On-site child care is provided at the YWCA shelter by PACT, a 2 day per week therapeutic nursery program for children up to 5 years old. Another source of child care for homeless children was recently made available through The Ark, a dedicated child care center operated by Episcopal Social Ministry. It began operation in October 1990 and has capacity for 20 children. The Ark program serves all of the family shelters and met with providers to devise a plan for allocating places. It provides a school bus to transport the children to and from the center.

Transitional Housing Program residents have access to day care at several locations around the neighborhood, including a day care center located in the same building. Links to this center are informal, however, and services are not guaranteed.

Availability of day care did not appear to be as much of a problem for housing project residents, with the exception of infant child care. The Housing Department provides space for several day care centers for children of residents, which are paid for through DSS subsidy. The one child care center site-visited was not operating with full enrollment. It was not clear if under-enrollment was a function of lack of DSS subsidies or over supply of day care. Staff seemed to indicate the latter. The housing projects also provide drop-in day care for mothers participating in other programs at the Family Support and Family Development Centers.

E. Other Support Services

Additional support services such as life-skills training, parenting training, and individual and group counseling are available to varying degrees depending on the program. Shelters try to do as much as possible to the degree that crisis intervention permits. Programs with the longer lengths of stay were able to offer a wider range of services. Participation in support services was considered mandatory to receive housing in some programs--for example, the THP and YWCA shelter--and offered as optional in other programs.

Training in parenting skills was a key component of most of the programs visited. Approaches included parent anonymous groups, training workshops, and peer counseling/mentoring. Other training topics addressed by some programs have included budgeting, cooking and shopping, and nutrition.

F. Employment and Training

Several options for employment and training were identified during the site visit. The key systemwide effort is Project Independence, which is Maryland's response to the Federal JOBS welfare reform program. Project Independence participation is mandated for all AFDC clients who do not fall into an exempted group--the key exempted group being mothers of children under 3 years of age. Participants are assigned an Intensive Case Manager (ICM) who is charged with eliminating all barriers to participation in training, employment, or education. Chief barriers are day care and transportation, and Project Independence participation gives a person priority for DSS subsidized day care.

Several barriers hinder participation in Project Independence by homeless families. First, ICM assignment is done at the district AFDC office. Homeless families' files are not transferred to the district office until they are "permanently" settled. Transient homeless families may never have their files transferred and therefore will not get an ICM assignment. Second, in Baltimore, many homeless mothers have young children and so are exempted from Project Independence unless they volunteer--which some do. Third, day care freezes have caused a logjam in the Project Independence system.

In addition, some informants believed that the Project Independence training prepares participants for low-paying jobs only, which will not lead to self-sufficiency. Project Independence was not felt to be having a major impact with homeless mothers, and several informants indicated that they did not expect it to have an impact. However, some indicated that the program is new and many wrinkles need to be worked out.

The Project Independence link is working better in public housing. For example, The Family Development Center at Lafayette Homes is designated as a training site for pre-GED, GED, and literacy training. It appears that most residents share the same ICMs, which enhances coordination. Several other job-related services are also offered through the Family Development Centers, which distinguishes them from the Family Support Centers. These linkages were facilitated by the fact that Housing and OED (the authority which oversees jobs programs) were part of the same city agency when the Family Development Center concept was initiated.

Most shelters that offer services attempt to offer opportunities for job skills training; however, the emergency shelters indicated that crisis intervention generally takes precedence until the family is stabilized and that the short duration of shelter stay often means the family is never stabilized. The Transitional Housing Program is the exception because clients stay for up to 2 years. Job training was the initial focus of the program although it has since shifted beyond that. However, a 12-week cycle of basic life skills/job skills programming is a core component of the counseling program. An employment counselor is on the staff at each facility and functions similarly to the old Job Training Partnership Act (JTPA) counselors. The service was brought in-house because staff felt JTPA counselors were steering clients into undesirable jobs and felt that in-house counselors could be more successful with their clients.

G. Other Program Linkages

Child Welfare and Protective Services. In Maryland, homelessness does not constitute *de facto* environmental neglect, nor is placing a child with relatives considered "abandonment" if the proximate cause is the mother's homelessness. However, homelessness may be a factor in parents' ability to regain custody of their children.

Some emergency shelter staff indicated that parenting education is a major need among their homeless family clients, especially issues related to discipline. The stress of homelessness may increase the parents' use of physical punishment. Shelters try to discourage use of physical punishment and usually have policies and signs posted reminding parents not to physically punish their children. These issues are handled largely on an informal basis. Linkages with the child protective services (CPS) system are also informal. Most programs seem to rely on the "street smarts" of their staff to distinguish parenting issues from neglect issues, and to know who to contact if the latter becomes apparent.

Entitlement System. Income maintenance programs are funded and coordinated at the State level and Department of Social Services employees are State employees. Theoretically, this division would seem to make it more difficult to coordinate social services at the local level since two levels of government must be in coordination. In reality, site visit informants believe that having two levels of administration does not compound coordination problems.

Homeless families are screened for entitlements at several points in the Baltimore service system. The more established shelters such as the YWCA screen for entitlements as part of their intake process; HCH also performs this function. Data from HCH indicates that about 21.5 percent of its clients in the first half of 1990 were members of families and that 18.6 percent (i.e. 86 percent of all family members) were receiving AFDC benefits. More than one-third (33.9 percent) of all HCH patients in the first half of 1990 were receiving Medical Assistance benefits or had applications pending; however, it is not known what percentage of families receives Medical Assistance benefits since coverage extends to single individuals as well.

The Department of Social Services has concentrated all essential services for homeless families in a centralized income maintenance unit. Case workers for this unit follow clients until they are housed; however, clients are considered housed when they are placed in shelter so are no longer followed at that point. The relationship of emancipated teens to the income maintenance system is unclear. Some informants said that teens are eligible for general public assistance and, if they have children, AFDC. Others indicated that they were closed out of these systems.

Substance Abuse Services. Although the site team was not able to examine substance abuse services directly, site visit informants related that these services are a major gap for homeless families. The main issue, according to informants, is not the availability of drug treatment, but its accessibility for homeless individuals and families. In general, treatment programs do not wish to treat the homeless and have done very little to accommodate their special needs.

Mental Health Services. The site team was not able to examine mental health services in depth. Informants indicate that mental health service providers are particularly innovative in their efforts to include the homeless. The RWJ-funded Baltimore Mental Health Systems, Inc. serves as the focal point for planning, coordinating, and funding mental health services at the local level for people with chronic mental illness. This agency has extended its outreach and service delivery efforts to include the homeless.

Domestic Violence Services. Three of the 52 emergency shelters in Baltimore are specifically targeted to victims of family violence. The major domestic violence shelter provider is the House of Ruth. For more than a decade, the House of Ruth has provided shelter and comprehensive services to homeless families with children and has become a model for replication throughout the State. Still, these shelters are unable to meet the need for services; emergency shelters serve as an overflow system for the many victims of domestic violence who cannot be served in the targeted shelters.

VI. General Issues and Barriers Related to Service Comprehensiveness

Baltimore's response to the problem of family homelessness has some identified strengths as well as service gaps and other barriers to a comprehensive and coordinated service system. Following is a summary of the major strengths and barriers that were consistently mentioned among several of the site visit informants and observed by the site visit team.

A. Strengths and Innovative Efforts

A particular strength of Baltimore's response to the needs of homeless families is the strong commitment at all levels to link families with particular needs to existing services. This is reflected in the activities of the Mayor's Office of Homeless Services, the Coalition for Homeless Children and Families, the Department of Education, and Health Care for the Homeless, as well as many individual providers. Baltimore's involvement in homeless issues has been centralized under the mayor in the Office of Homeless Services. This office provides leadership in the planning and coordination of homeless services, both among government agencies and non-profit providers. In addition, the fact that the city and county are the same jurisdictional entity and that the Housing Department encompasses the Housing Authority and--formerly--the employment training resources, has led to innovative approaches to linking housing, jobs, and social services. It has also contributed to more collaboration in implementing the JOBS welfare reform program, Project Independence, than was found in the other cities visited.

These service system characteristics have enabled Baltimore to do a better job than most cities of minimizing service duplication. Through the Coalition and other efforts, service providers have joined forces to obtain scarce funding and coordinate service delivery efforts.

B. System Gaps and Barriers

Case Management. In spite of the overall system coordination, there is no designated case management function. Linkages are made to the mainstream system services; however, there isn't any assurance on a case-by-case basis that services were delivered in a coordinated fashion. Providers feel that the case management role is underfunded and that programs lack resources to put it in place.

Followup/Aftercare. The lack of follow-up services is widely recognized as a major gap in Baltimore's system for serving homeless families. This gap is viewed as a major cause of recidivism, which most informants believe is high, although the information is only anecdotal. While services provided by some shelters are intensive during the maximum 13-week stay, supports disappear once the person moves to permanent housing because no one is charged with following up. The need for follow-up services is heightened by the lack of transitional housing opportunities which ensures a longer period of services. There are several efforts underway to help fill this gap. The YWCA Family Mentor Program plans to match a homeless family with a mentor who will maintain contact with them even after obtaining permanent housing, and Family Start, which finds and assigns a "family friend" to 15 families to assist them throughout the program's duration. The Transitional Housing Program is also instituting follow-up by hiring additional staff to deal just with this issue. Program staff found that "graduates" were continuing to draw on program resources and were diverting attention from the core program services. Since program graduates usually secure Section 8 certificates, they tend to cluster in same neighborhoods. Staff hope to use this proximity as a base for a continuing community of support.

Transitional Housing. Although shelter providers attempt to help departing clients become linked with transitional housing, there are rarely any spaces available. Shelter providers feel that most of their clients would benefit from services lasting longer than the typical 13 week shelter stay. Although some shelters attempt to provide an array of support services, many report that they are unable to move beyond crisis intervention during that short time period.

Day Care. Like most cities, Baltimore has a shortage of affordable day care opportunities for low-income families. This is made more severe by the freeze in DSS subsidies. A day care program dedicated to serve homeless families recently opened; however, the program is too new to determine if it will fully meet the needs.

Funding. The lack of sufficient funding was repeatedly identified as the main obstacle to developing services. Although, it was recognized that this gap served a positive role in forcing collaboration to stretch available dollars. One side effect of limited funding is low staff salaries. Nevertheless, at the executive level, very dedicated and professional people predominate. However, many informants reported difficulties in recruiting and retaining staff at the aide and case worker level.

Evaluation. Evaluation efforts among the programs visited were sporadic. Individual programs vary in their data collection and analysis capabilities. None of the programs visited have been able to follow clients through the system to measure impact on long-term self-sufficiency. A current effort underway by Johns Hopkins University will evaluate the effectiveness of interventions of various programs, including the Family Development Centers and the Transitional Housing Program. As national demonstration projects, both RWJ and Family Start have large evaluation components. Family Start includes a matched set of families who will receive an annual stipend but not receive the interventions. Evaluation findings will be useful to guide future efforts and to help ensure that successful programs are replicated.

Program Profiles

Baltimore, Maryland

Family Start Program

Organizational Issues

The Family Start Program is one of 24 Comprehensive Child Development Centers in the country, funded and administered by Head Start as 5-year research and demonstration programs. Its focus is on families with infants and young children up to age 5. The Family Start Program in Baltimore is located in the Lafayette Multi-Service Center, a large, multipurpose community building in the western part of the city.

Families in the Family Start Program are living on the edge; they are poor and are either expecting a child or have a child under 6 months old. The goal of Family Start and other Comprehensive Child Development Centers is to enhance children's development. To help achieve this goal, a primary program focus is on empowering families to help themselves. These programs also attempt to create a structure within the community to link families with needed services. In Baltimore's Family Start Program, these activities are occurring both at the multi-service center and in residential homes, using both professional staff and trained members of the community.

Family Start received funding in October 1989 and, as of November 1990 (the time of the site visit), had been in operation for less than 2 weeks.

A total of 360 families were recruited for the 120-family experimental group and 240-family control group. The control group families were offered a stipend of $50 paid twice a year to participate in annual screenings and assessments, while the experimental group families were offered the program's services.

According to Family Start Program staff, the average family served is headed by a single woman age 15 to 35 years, who frequently has less than a high school education. Very few of the women are employed; those who are have relatively low paying jobs. Although the program does not target the homeless, a significant number of the families in the program are marginally housed and/or have cycled in and out of homelessness in the recent past.

Points of Entry

The program is open only to families in a designated catchment area and who meet certain criteria. Services will be very accessible, including some that will be offered in the family home.

Families are being recruited into the program. The first year of the Family Start Program was spent on recruitment of experimental group families and control group families. This effort was carried out through local health and social service clinics and door-to-door solicitation. As capacity permits, the program will be open to new families in the catchment area who meet the criteria.

Service Delivery

To be eligible for Family Start, clients must be pregnant or have a child under 6 months old, be at or below the poverty level, and live within the program catchment area that includes several neighborhoods in West Baltimore, and must agree to participate for all 5 years of the program. Once in the program, all members of the family are encouraged to participate in the program activities.

The Family Start program offers a variety of services to family members in the experimental group. These services are offered both at the center and in the family's home. Services at the multi-service center include drop-in day care for the children, parenting classes, GED and continuing educational instruction, literacy programs, visiting nurse health checkups, and infant developmental assessments. The topical content of the program is being determined by the expressed interest of the mothers in the experimental group.

The outreach component is carried out by trained community members called Family Friends who visit families in their homes. Each Family Friend assists families with parenting skills and issues that may arise such as getting access to needed resources or budgeting the family income. Each Family Friend assists 15 program families.

The program is prepared to meet needs of special populations such as mentally ill or substance using homeless women, and is in the process of developing the necessary referral links to do so.

Coordination and Effectiveness of Services

The Family Friends fill the case planning function. The Family Start Program is designed as a research demonstration project. The purpose of offering access to coordinated services for some families while offering only reimbursement for their time to other families is to test the effect of Family Start Program activities. At this point in the program no outcome data are available.

Financial Issues

The main funding source is an $880,000 annual Federal grant from Head Start. This is matched by local funds (local match was recently increased from 25 percent to 33 percent).

Staffing

Family Start has a total of 27 staff including a director, deputy director, an employment specialist, 2 child development specialists, 2 family services coordinators, a men's services coordinator, a resource coordinator, a data manager and assistant, a teacher, an aide, and a van driver. The director has many years of experience working in Baltimore's homeless system at the emergency shelter and transitional housing level.

Family Start also employs eight trained community members to serve as the family friends. The individuals come from a wide variety of backgrounds such as social work, substance abuse, and the religious ministry. Before each family friend is sent out to the community to assist the assigned 15 program families, he or she is trained in child development, domestic violence, safety, and ways to obtain access to community resources.

Issues and Barriers Identified

Since the program has only just begun, staff stressed that it was too early to discuss any program findings. However, staff felt that financial support for their program is insufficient.

The philosophical bent of the program staff is that families need to be assisted to help themselves within their own communities and based on their particular community's unique needs and resources. Over the long term, staff thought that the most effective way to help homeless families is to improve the mainstream services delivery system for families who are low-income or otherwise at risk.

YWCA of Greater Baltimore, Inc.
Eleanor D. Corner Emergency Shelter

Organizational Issues

The YWCA of Greater Baltimore operates the Eleanor D. Corner Shelter, a shelter for homeless families with children in downtown Baltimore. It offers shelter for up to 70 family members per night. The YWCA offers an array of support services to assist sheltered families in their efforts to reestablish self-sufficiency and independence.

Shelter staff described the typical shelter resident as between the ages of 18 and 25 years, African-American, with a high school education, unmarried with two to three children, unemployed, and receiving AFDC.

Points of Entry

Most families find out about the YWCA shelter and its services through word-of-mouth. Some families are referred from other shelters through Baltimore's information and referral system. Some have been turned away from other shelters either because of a lack of space or appropriateness or because they had reached the maximum stay allowed.

Requests for shelter at the YWCA are handled on a first-come, first- served basis. Often, the YWCA is full and families must be turned away. Shelter staff estimate that in 1989, between 450 to 500 individuals were turned away. If space is available, families find that YWCA eligibility criteria for entrance to the program are broader than in most shelters. The YWCA accepts women with children up to age 17 years, and is one of the few shelters in the city that accepts intact families.

Service Delivery

While at the shelter, families have their own private rooms. They also have access to other facilities such as a lunch room and laundry facility.

In addition to providing room and board, the YWCA offers families support services to help them become more self-reliant and economically self-sufficient. While at the shelter, families are offered case management and on-site therapeutic day care. Families can also receive after-school tutoring and preschool-age day care services off-site.

For preschool-age children, the YWCA offers shelter residents access to the Therapeutic Day Care Program, an early intervention and family support service for children ages zero to five years. The day care program is operated on-site two days per week by PACT (Parents and Children Together), a private agency, and is funded by the Baltimore City Health Department. The program offers children a warm, nurturing environment that is intended to help them build their self-esteem and coping skills. All children are tested for possible developmental delays using a well-known developmental screening test. If a delay is discovered, the child is referred to PACT's main office for therapy, if the parent agrees. The Therapeutic Day Care Program also has a mandatory parenting component. Before their children can participate in the day care program, parents must agree to attend parenting support groups. At the time of the site visit, the Therapeutic Day Care Program was full and had a waiting list.

The YWCA Eleanor B. Corner shelter has direct service linkages and referrals to a number of outside programs. For example, preschoolers at the shelter may receive day care services at the newly opened day care center for homeless children, The Ark. School-age children may receive tutoring after school through the State Department of Education's Helping Hands tutoring program at nearby Enoch Pratt Library.

The YWCA also provides services to homeless children outside its own shelter residents. At the Springhill Transitional Housing Program the YWCA operates the infant care program. As part of its activities as coordinator for the Coalition for Homeless Children and Families, the YWCA will help provide mentoring services for homeless families in the Baltimore community. As part of the Robert Wood Johnson Homeless Families Program, the YWCA will implement the Family Mentoring program and manage the transportation system. Finally, as discussed separately, the YWCA plays a major role by acting as the lead agency for the coalition.

Most families in the shelter are on AFDC. Staff do not find accessing AFDC to be a problem for homeless families. Health services and services for pregnant women are more problematic. To address these issues, YWCA staff are trying to have WIC application services on-site once a month. In addition, staff offer pregnant women transportation to their prenatal care appointments. Staff hope to offer children in the shelter better access to well-child services through the Ark Day Care Center, which will have a visiting pediatric nurse from the Health Care for the Homeless Project.

Families can stay at the YWCA shelter for up to 13 weeks; however, on average they stay 21 days. The shelter director believes that when families leave the shelter they typically move to housing projects, to their own apartments, in with relatives or friends, or are referred to a Department of Social Services emergency service such as drug treatment. According to the director, very few families move from the shelter into transitional housing because so few openings are available.

Coordination and Effectiveness of Services

For families, the shelter offers case planning and care coordination services. Upon intake, families discuss their service needs with the shelter staff and a work plan is drawn up to address these needs. Shelter counselors meet with families twice a week to discuss the problems families may be facing. They also offer the family advice on how to negotiate the city's service delivery system. Shelter staff may broker services for families who find permanent housing. These services may be as basic as finding a ready supply of diapers or as complicated as finding the family furniture or assisting with start-up services such as gas and electric utilities.

The YWCA feels that they are more successful than most shelters in cycling families out of the shelter system and into permanent housing. They attribute this success largely to the support services they provide. According to shelter staff, the recidivism rate for families leaving the shelter and then returning at a later date is 6 to 7 percent.

Nevertheless, the YWCA staff often lose track of the families after they leave the shelter. Although staff have attempted various tactics to get families to send their new address, such as a postcard system, these efforts have not been very successful. As a result, staff are unsure of the long-term housing status of the families they serve.

Financial Issues

Funding sources include United Way, governmental grants, fees for classes and recent foundation grants including $100,000 in leveraging funds and $23,000 to support The Ark Day Care Center in which the YWCA participates.

Staffing

The YWCA Corner Shelter is a unit of the YWCA of Greater Baltimore. The YWCA has a full-time executive director; the shelter is under the direction of a director of residential services and a shelter director. Two counselors per floor and one group aide per shift provide frontline services to the families in the shelter. The counselors are required to have a Bachelor of Social Work degree with some experience and are paid $7.36 per hour. Group aides earn $5.20 per hour. Because of their low wages, often staff are not much better off economically than the shelter residents; frontline service staff turnover is a problem.

Staff for the Therapeutic Day Care Program include a social worker, teacher, and three teaching assistants, and a consulting child psychologist. The current staff to child ratio is 3 to 1. In the future, PACT intends to add volunteers to the staff so that more children can be served by the program while maintaining the same low staff to child ratio.

Issues and Barriers Identified

YWCA shelter and other program staff identified several service delivery issues. According to the shelter staff, although the city has an information and referral system, there has been no move toward a central intake system because of inadequate capacity in the shelter system in general. One staff member said, "You could put the families on a bus, but more times than not, there would be nowhere to send them."

Staff report that most of their shelter residents have ongoing relationships with Child Protective Services (CPS). Often, CPS caseworkers are pleased to discover that families are receiving shelter at the YWCA; as a result shelter residents may regain custody of their children while they are staying at the YWCA.

YWCA staff feel that the lack of availability of low-income child care in Baltimore is a major problem. Staff are working with the State child care licensing agency to develop a pilot initiative allowing homeless families to have priority access to subsidized child care services.

Episcopal Social Ministries
The Ark Day Care Center

Organizational Issues

The Ark Day Care Center, operated by Episcopal Social Ministries, provides day care services to homeless preschool children. The program can serve up to 20 children each day. Children are transported by bus from emergency shelters to the center, which is in the basement of a small Episcopal church in a predominantly blue-collar neighborhood of East Baltimore. There the children find a large room painted in soft, muted colors, filled with toys and private areas for children to play both indoors and outdoors.

The Ark is currently the only day care center in the city for homeless children. Its creation is the result of efforts by Episcopal Social Ministries and members of the Coalition for Homeless Children and Families to "do something for the kids." The Coalition consists of shelter providers as well as funding groups and other interested parties. Working together, these groups were able to tap a number of different funding sources. The center opened its doors in October 1990, just a few weeks before the site visit.

Points of Entry

Access is through the participating emergency shelters. Before the center opened, The Ark staff met with shelter staff to inform them of the availability of day care slots and to obtain their commitment to referring homeless children to the program. A variety of organizations, including the YWCA, Episcopal Social Ministries, and other emergency shelters, committed to filling the 20 day care slots. Each shelter is assigned a designated number of slots, if a child moves from one shelter to another, the slot may temporarily move with that child.

The center is open 8:30 a.m. to 3:30 p.m. on weekdays. Currently, the YWCA of Greater Baltimore arranges the bus transport of the children from shelters to The Ark.

Service Delivery

During operating hours, children are offered child care services and meals. Once a week, the children can receive health check-ups from a visiting pediatric nurse from the Health Care for the Homeless Project. In addition, parents are offered parenting discussion groups.

Besides working with the emergency shelters who refer homeless children to the program, The Ark uses the services of Lutheran Social Services to provide meals for the children during the day.

Duration of services is tied to shelter residency. Shelter residency varies widely among Baltimore shelters.

Coordination and Effectiveness of Services

Staff expect that there will be little chance to provide services to the children except during the hours the children are actually at the center. Since the shelters will be responsible for filling the day care slots, The Ark staff expect that the shelters will ensure that the slots are used wisely and in a manner most beneficial for the children. Many services are available to families via the Coalition, such as mentoring, tutoring, job counseling, and housing assistance. This leaves The Ark free to focus exclusively on the needs of the children.

The center had only been open a few weeks at the time of the site visit. Plans for tracking client outcomes are being designed by staff of Johns Hopkins University's Institute for Policy Studies.

Financial Issues

It was originally estimated that The Ark would cost $30,000 to develop and get underway. With assistance from the coalition, $20,000 was raised from United Way and the other $10,000 from foundations. Ark staff soon discovered, however, that the church building was in poor shape and the basement was suffering from water damage. In the end the renovation cost $80,000. The additional funding came from a variety of sources. The State of Maryland contributed $30,000, the Abell Foundation $20,000, and a variety of other donations added a total of $5,000.

The Ark estimates that its annual operating budget will be $120,000. Restricted funds from private philanthropies, individuals, and especially corporations provide 60 percent of the operating budget. Unrestricted funds, from Episcopal Social Ministries and other sources make up the remainder of the budget. The program receives no public funds.

The center has received in-kind donations of assistance and donations of toys from many private individuals.

Staffing

Staff at The Ark includes one director, two senior staff, and two aides. The program requires that senior staff be at least 21 years old and high school graduates; aides must be at least 16 years old. The Ark director reported that she uses the Maryland Department of Human Resources guidelines for child care workers to determine appropriate levels of staff experience. The senior staff received training in working with at-risk children from the Bank Street College of Education in New York.

Barriers and Issues Identified

The Ark staff had a number of comments for others who consider starting a similar program. The cost of the physical plant can be a prohibitive factor in developing a day care project. For The Ark this ended up being a major component of the center's cost.

Collaboration among homeless service providers is vital in developing a program of this kind. Without the contributions and cooperation of numerous organizations and individuals, the center would not have had access to as many resources as it did.

The mothers of the children may need to be included in program activities. Ark program staff have found that because the parents' lives are in such a state of chaos, it is often emotionally difficult for mothers to let their children out of their sight. Consequently, The Ark staff have placed additional emphasis on bringing mothers into program activities.

Health Care for the Homeless Project

Organizational Issues

Baltimore's Health Care for the Homeless Project is a nonprofit agency organized to coordinate health services for homeless individuals and families. The agency was created in 1985 through a grant from the Robert Wood Johnson Foundation as a cooperative venture of Associated Catholic Charities, Baltimore City Health Department, Johns Hopkins Medical Institutions, Mercy Medical Center, Old Town Podiatry, and the Health and Welfare Council of Central Maryland. The partnership has since expanded to include many other medical clinics and services. The project currently receives funding from the Federal McKinney Act, the State of Maryland, and various other funding sources.

Originally, Baltimore's Health Care for the Homeless Project services were provided at two shelter-based mini-clinics. However, in 1987 all services were consolidated at one site in downtown Baltimore. This site offers three main types of assistance: health care, mental health, and social services. There is an outreach component for each of the three types of assistance.

In 1989, the Health Care for the Homeless Project recorded nearly 20,000 patient encounters. Half of these encounters were for medical services; 22 percent were for social services; and 12 percent were mental health-related. An additional 3,000 individuals were reached through the project's public education efforts. Staff report that three-fourths of the project's clients are male, and nearly as many are between the ages of 20 and 44. Minorities are disproportionately represented among the clinic's clientele; 65 percent are African-American. Almost half of the clients have at least a high school education but the overwhelming majority are unemployed.

Points of Entry

Outreach activities may involve visiting soup kitchens and shelters, visiting sites where enrollment for medical assistance and financial assistance is processed, and talking to homeless individuals on the streets. Staff also perform outreach to health care providers in the mainstream system. There is no limit to duration of service so long as a person is homeless and they will follow people who may have secured housing until they feel they are stable. Outreach staff use area health centers and make other types of appropriate referrals. Clinics are open 7 days per week from 9:00 a.m. to 5:00 p.m.

Service Delivery

The overriding philosophy of the Health Care for the Homeless Project is to link the homeless to mainstream service delivery systems where possible. Consequently, the role of the project is to train and pressure the mainstream system, and to fill in the gaps in the delivery system only where absolutely necessary.

The downtown Baltimore clinic offers the homeless medical, mental health, social work, outreach, and educational programs. Where possible, the Health Care for the Homeless Project makes referrals to the mainstream health and human services system for acute care services, prenatal and obstetrical care, dental care, podiatry, ophthalmology, pharmacy, laboratory and x-ray services, substance abuse treatment, and transportation services. When staff refer a client it means that they set up an appointment; they track patients on a limited basis to see whether or not the appointment was actually kept. Project staff estimated that about half of those clients referred to outside programs actually show up for their appointments. They provide some transportation vouchers to facilitate access.

In addition to referring clients for direct medical services, Health Care for the Homeless assists client in accessing financing for these services. Staff refer homeless to sites where they can enroll in Medical Assistance, WIC, pharmacy assistance, and SSI.

The Health Care for the Homeless Project recently became involved in providing more in-depth health services to homeless children off-site at four to eight other facilities. A community health outreach nurse, hired and supervised by Health Care for the Homeless, will provide health services to homeless children at The Ark Day Care Center in East Baltimore. The nurse will work in collaboration with The Ark staff in performing screenings and assessments to identify health needs of the children, provide acute care when needed, and make referrals for primary care to community health centers or area hospitals.

Where they can, staff provide nonhealth services as needed. For example, staff report that they get a few vouchers for shelters each day and use them to offer shelter to clients who, because of their medical status, are particularly in need of shelter.

Coordination and Effectiveness of Services

In some cases, the programs to which the homeless are referred perform case planning services. For example, pregnant women referred to Mercy Medical Center for high-risk obstetrical services receive case planning services there. Limited follow-up with clients is performed; however, unless clients return to the clinic, staff often do not know their long-term status.

Financial Issues

The total budget is $1.3 million; 38 percent is through Federal McKinney dollars, 46 percent is State funding, and 16 percent is from Comic Relief and private in-kind donations.

The project does receive Medicaid reimbursement for some services. The staff is trying to get Medicaid intake workers outstationed at the clinic to ease the application process for patients.

Staffing

The study team spoke with the coordinator for health outreach and a social services outreach worker. Both work with homeless families with children as well as homeless individuals in general. In addition, the project has a sizeable staff of paid and volunteer physicians and nurses.

Barriers and Issues Identified

Health Care for the Homeless staff felt that children in particular should be served in the mainstream system because services are generally available. However, prevention efforts still need to be stressed. They mentioned that homeless children often do not receive the preventive health services they need such as well-child care check-ups, immunizations, and developmental assessments. Teenagers as a group often fall through the cracks; however, they do outreach at the teen shelters.

Staff indicated that the strategy of linking the homeless to the mainstream system would work better if the homeless were offered more education on how to navigate the service delivery system. They have been trying to sensitize other health providers to the needs and circumstances of the homeless.

The fact that many shelters in Baltimore are only open at night makes it difficult for homeless people to keep their health care appointments. Clients who are working may have to choose between standing in line at a shelter to get a place to sleep that night or keeping a health clinic appointment.

The Transitional Housing Program, Inc.

Organizational Issues

The Transitional Housing Program (THP) is the largest program providing transitional housing to homeless families in Baltimore. The program operates at two sites: the Rutland Apartments and the Springhill Apartments. Families are offered housing and a variety of support services for up to 2 years, but average 15-month stays. The goal of the program is to provide these families with a safe environment, where with access to resources, families can work towards building self-sufficiency and a secure future.

The THP was conceived in early 1987 as a means to assist homeless families. Through a large donation from a private benefactor the program got off the ground. The donation was used to transform two vacant public schools into multi-service centers with newly decorated common rooms, playrooms, offices, and attractive private apartments, each with a living room, bedroom(s) and kitchen. The first site, the Springhill Apartments, opened in November 1987 and the second site, the Rutland Apartments, which can accommodate larger families, opened in December 1988.

Points of Entry

The majority of families served by the THP are referred to the program from Baltimore emergency shelters. A much smaller number of families are referred from the child welfare system or religious organizations. Potential program participants are screened by telephone to determine if they will benefit from the program. The initial telephone interview is followed by a series of in-person interviews. The parent(s) is(are) first interviewed at the emergency shelter where the family is staying. If the case is reviewed favorably by the THP staff, the entire family is interviewed at the THP and told about THP and its services in detail.

Often, both programs are full. THP staff report that the Rutland Apartments usually have a 100 percent occupancy rate. Because its apartments are smaller, Springhill may have rooms but they may not be appropriate for a large-size family.

Families may not enter the program with an active substance use problem, active mental health problem, or overt behavioral problem. However, once in the program, THP can link those who develop drug problems with detox programs and with an in-house aftercare program.

In order to participate in the program, parents must be at least 18 years old and have at least one child. At the Rutland Apartments, families with children over age 15 are not accepted; at Springhill, children must be under 12 years.

Service Delivery

Once a family moves into either Rutland or Springhill, staff try to give the family a period of time to adjust. After this point, parents are asked to draw up a residential agreement with the staff. This contract specifies that the family will participate in THP's counseling, employment, or educational services. It also lists the individual's goals and methods for achieving them. Every 3 months this agreement is reviewed and revised as needed.

To assist families in achieving their goals, THP offers a range of services including job training, academic counseling, family life skills training, day care, individual and group counseling, parenting classes, relocation services, and follow-up contacts and services. Children attend school in the neighborhood and are offered after-school tutoring on-site. Some preschool-age children attend Head Start and are transported to and from the program by bus. Other preschool-age children are in day care programs off-site or education/development programs on-site. The THP encourages parents to participate in the discussion groups and parenting classes that are offered in conjunction with the children's program.

THP has arranged with the Baltimore Housing Authority for graduates to receive priority access to Section 8 housing. This allows for more of a housing continuum for these families.

THP is working closely with Project Independence, Maryland's JOBS welfare reform program for AFDC recipients. Program participants have access to Project Independence day care slots.

THP tenants receive their health care at a variety of locations: at HMOs, through private physicians who accept Medical Assistance, and from the Health Care for the Homeless Project.

Families are offered 6-month leases that are renewable for up to 2 years. The average length of stay is approximately 15 months.

Tenants in the Rutland or Springhill Apartments may leave at any time. Some families leave if they find other housing, or they may be asked to leave if they are disturbing other tenants. (Tenants themselves have significant input into these types of policy and procedure decisions.) Some families relocate to the same nearby, low-income areas; about half of the graduates have relocated to better areas of the city. The THP program staff offer families some assistance in relocating but do not offer longer term support services after they leave the program.

Coordination and Effectiveness of Services

As described above, upon entrance to the program families sign a contract to work on their goals and to abide by the program and house rules. During this time families work with the program counselors and participate in both on-site and off-site programs and services.

The THP defines a tenant's success or "graduation" from the program as six months of (1) maintaining employment or enrollment in school, (2) participating in counseling, and (3) meeting goals in the residential agreement to the counselor's satisfaction. According to program staff, many families leave the program without graduating because their names come up on the list for public housing. Other individuals leave voluntarily. Finally, some individuals are asked to leave.

Given these caveats, a total of 40 out of 150 participants have graduated from the Transitional Housing Program. Staff believe that the impact of THP on families' lives is much greater than these numbers indicate. During the 1 to 2 years that a family is in the program, staff often see a major turnaround in the family's ability to achieve self-sufficiency.

The program is initiating a followup component. The followup worker will begin working with the family 6 months before discharge to help with transitions and will also track outcomes such as maintenance of permanent housing, progress in school or jobs, and children's progress. The Institute for Policy Studies at Johns Hopkins University will have a role in the followup component.

Financial Issues

The funding for most of the cost of renovating the THP physical plant came from one family's private donation. Additional renovation funds were collected from other private donations, emergency shelter grants, Urban Development Action Grants, and Baltimore City Community Development Block Grant funds.

According to the program staff, funding for daily operations has been more difficult to obtain. Currently, program and service funding stems from many sources: tenants, who pay 30 percent of their adjusted gross income as a program fee; a HUD demonstration grant; foundation funding; Baltimore City and Maryland Department of Social Services; and individual and community groups.

Staffing

THP program staff include an executive director, program director, an addictions counseling specialist at each location, an education development specialist (for GEDs) at each location, a life skills counselor at each location, and two part-time followup staff who work with families from both locations.

Staff burnout is a constant threat at the THP. In order to prevent this, the executive staff have instituted a weekly staff workshop and may allow staff to work 4-day weeks or shorter days when deemed necessary.

Issues and Barriers Identified

An area where staff believe the program could be improved is in the provision of followup services to families. Often families have no furniture and household appliances when they leave, and although residents are responsible for making sure they have security and utility deposits by the time they leave, sometimes they do not.

The intended relationship with Project Independence is not working as well as their prior relationship with the Office of Jobs and Training. THP had hoped to become a training site under Project Independence in order to have more control over the types of programs to which their participants were referred. This does not appear likely.

Day care is a major gap for these families. In the past, THP participants received expedited day care vouchers and had a link to DSS employment services. Now, THP clients compete with all Project Independence participants. Staff would like to have Head Start on-site or full-day. For parents who are employed, having to work around the lack of day care or half-day Head Start is a problem.

The staff would like to institute a special class for children of substance abusers.

Robert Wood Johnson Foundation Homeless Families Program

Organizational Issues

Baltimore's Robert Wood Johnson (RWJ) Homeless Families Program is a 2-year pilot project to develop a more comprehensive infrastructure for serving homeless families that includes both housing and support services. During the grant period, a total of 190 families will be served through the RWJ grant and Housing Authority of Baltimore City funding and services.

The Mayor's Office of Homeless Services, the office that performs planning, coordination, and program management for homeless services in the City, is responsible for administering the grant. The physical location of the program will be downtown in Baltimore City's Housing Application Office, which is also the site for public housing and Section 8 applications and processing.

The components of the program include: (1) an intake and screening unit to interview and begin the housing assistance process for 190 homeless families; (2) case managers who will work with homeless families in either of two public housing developments or who have been given rental assistance to find housing in privately owned units; and (3) a volunteer family mentoring program to work with the case managers and families in the program.

Points of Entry

Initially, participants in the program will be drawn from the Housing Authority of Baltimore City's public housing waiting list. In addition, service providers at emergency shelters for the homeless and social service providers will be able to call the Homeless Families Program Center to refer families wishing to participate in the program. Any family willing to participate in the program is eligible so long as the head of the household is not in need of residential drug treatment services. In this case, the head of the household would be referred to a drug treatment program and would be eligible after successful completion of the program. Section 8 certificates will be limited to families with preschool-age children.

Service Delivery

Families are interviewed and then referred for either Section 8 housing or to public housing at Lafayette Homes or Lexington Terrace, two public housing programs with Housing Authority-sponsored comprehensive service programs. Those families who move into public housing are assigned a case manager and a family mentor. Families who receive Section 8 certificates are assisted in finding housing, given a 6-month Rental Assistance Program certificate, assigned a permanent case manager who will be located permanently at the housing development and introduced to a family mentor.

After working with the case managers and family mentors for six months, if the family demonstrates the ability and willingness to continue in the program it will be issued a Section 8 certificate. These certificates will be limited to families with preschool-age children. A total of 140 Section 8 certificates will be available. They will be of two types. The majority will be traditional unrestricted certificates on the open market and the rest will be project-based certificates. Finally, the Housing Authority of Baltimore City will contribute priority public housing to another 50 families. It is the intention of the program to encourage families to resettle in the neighborhoods where Family Support Centers are located. Program support services are available as long as needed; but 2 years is expected to be the average duration.

Coordinated services will be provided to children at the Family Support Centers. Day care will be provided at The Ark Day Care Center.

The RWJ Homeless Families Project involves a large number of organizations acting in partnership including the following key actors:

- Mayor's Office of Homeless Services. The Mayor's Office will perform the initial screening of applicants from shelters and local social service agencies for the RWJ Homeless Families Program. The office will then send the applications to the Baltimore City Housing Authority, Housing Application Office. The Mayor's Office will also oversee the case managers.

- Friends of the Family, Inc. This group administers the Family Support Centers.

- Department of Housing and Community Development, Relocation Division. This division will provide assistance in finding permanent housing. It will also oversee the Rental Assistance Program. Finally, it will arrange some move-in services.

- Department of Housing and Community Development, Special Projects. This division will provide funds to supplement the Rental Assistance Program payments if necessary, and will direct emergency shelter grants.

- Department of Housing and Community Development, Financial Resources Division. This division will provide financing to Section 8 property owners who rent to RWJ Homeless Families Program participants.

- Housing Authority of Baltimore City. The Housing Authority will handle the processing of Section 8 applications and will expedite transfers from emergency shelters for the homeless to public housing units. It will also provide priority public housing to 50 families in the program.

- YWCA of Greater Baltimore. The YWCA will provide space and hire the Family Mentors. In addition, the YWCA will operate a transportation program for homeless families, to which the RWJ families will have access.

Coordination and Effectiveness of Services

The case managers and family mentors, together with the family, will discuss issues and problems to be addressed over first 6 months after joining the project and agree to a course of action to meet goals. Case managers work with families for as long as they want or need assistance; however, it is expected that most families will be able to manage independently within 2 years of program participation.

As of early 1991, the program had not begun serving families. Consequently, at this point, no outcome information is available. However, the program's goals are to increase the following: the number of families in permanent housing situations; parents obtaining GEDs or jobs; children with special physical, mental, or emotional needs diagnosed and treated; children immunized and receiving regular health checkups; adults with substance abuse problems in drug treatment.

Financial Issues

The major funding source is the $300,000 grant from the Robert Wood Johnson Foundation, along with the 140 Section 8 certificates.

The city has also received a $155,000 grant from the Better Homes Foundation which will be used to complement the Homeless Families Program. The focus of these funds will be pregnant homeless women; the funds will hire an additional 3 nurse case managers. A total of 100 families will be served in this component.

Staffing

Staff will consist of a program director, assistant program director, 6 RWJ-funded case managers, 3 Better Homes Foundation-funded nurse case managers who will work under subcontract with the Baltimore City Health Department, a family mentor program director, and 190 volunteer family mentors.

Issues and Barriers Identified

The program is just getting started; it is expected that the first families will enter the program in June 1991.

Chapter III

Site Visit Report

Boston, Massachusetts

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I. Introduction

Boston was selected as one of the five sites for in-depth case study because it represents a service approach characterized by a strong State funding role. Massachusetts is widely known for the extent of its human service infrastructure and for its commitment to funding it. The site visit team was interested in examining the role of homeless services in such a funding climate. Boston and Massachusetts are also known to have several innovative approaches to providing services, in particular a much-publicized attempt to deal with prevention of family homelessness by helping at-risk families find housing through a State rental subsidy program. The team also had been told that the system in Boston was innovative but fragmented, so there was interest in examining how myriad independent programs built links.

Unfortunately, the last few years have not been kind to Massachusetts or Boston. The economic recession began earlier and has been deeper in New England than in the rest of the Nation. This has greatly affected most of the reasons for choosing Boston as a site visit. Funding of the human services system has been cut; advocates feel that homeless services have been especially hard hit, and the much-praised rental subsidy program was never fully implemented. The economic conditions have also influenced the nature of relations both between service providers and government and among service providers themselves. A fortress mentality seems to have developed within government and the provider community, and providers, who heretofore may have been able to exist autonomously, have banded together in ways not seen earlier.

II. Overview of Site Visit

Boston was visited by the Macro study team and the ASPE Project Officer on December 11, 12, and 13, 1990, to explore how the city's existing programs and service delivery system are meeting the needs of homeless families with children.

Officials from the following city and State government offices were interviewed:

- Massachusetts State Office of Community Development
- Massachusetts State Department of Education
- Massachusetts State Department of Public Welfare (DPW)
- City of Boston Emergency Shelter Commission

Advocacy and interest groups interviewed included representatives of the following:

- Greater Boston Legal Services
- Massachusetts Coalition for the Homeless
- Fund for the Homeless
- Massachusetts Shelter Providers Association

In addition, the study team interviewed staff and toured facilities of the following programs:

- Medford Transitional Housing operated by Shelter, Inc.
- Project Hope, one of the first State-funded shelters and model program for the subsequent network of shelters
- Kidstart--Boston Children's Hospital which makes weekly visits to hotel/motels with a service team of physicians, child psychologists, and bilingual nurses
- Women, Inc., a transitional program for substance abuse recovery
- Cambridge Department of Human Services Multiservices Center, a center offering limited collocation of services
- Cambridge Salvation Army Day Care Center
- Network for Children, which offers onsite services to families in hotels/motels in the Boston suburbs

The purpose of these discussions and program surveys was fourfold: (1) to gain a general understanding of the size and scope of the problem of family homelessness in Boston, (2) to outline the service delivery system in the city as it serves these families, (3) to describe innovative service programs, and (4) to identify issues and barriers preventing homeless families in Boston from receiving the services they need.

Exhibit 1 describes the interview participants in the site visit. Exhibit 2 is a flow diagram depicting the interrelationships of the major components of the service system for homeless families in Boston. Profiles of the programs visited are attached in the appendix. These represent selected examples of some of the programs that compose the service delivery system in Boston.

III. Contextual Issues

As in cities and counties across the Nation, in Boston there is no single factor responsible for family homelessness. Rather, many factors combine to increase the risk that an individual or family will become homeless.

The approaches to addressing the issues presented by family homelessness are heavily influenced by the social, political, and economic environment. This next section describes the characteristics of the homeless family population, some of the factors related to causes of family homelessness, when and how a response to the problems took shape, and the political and social climate in Boston.

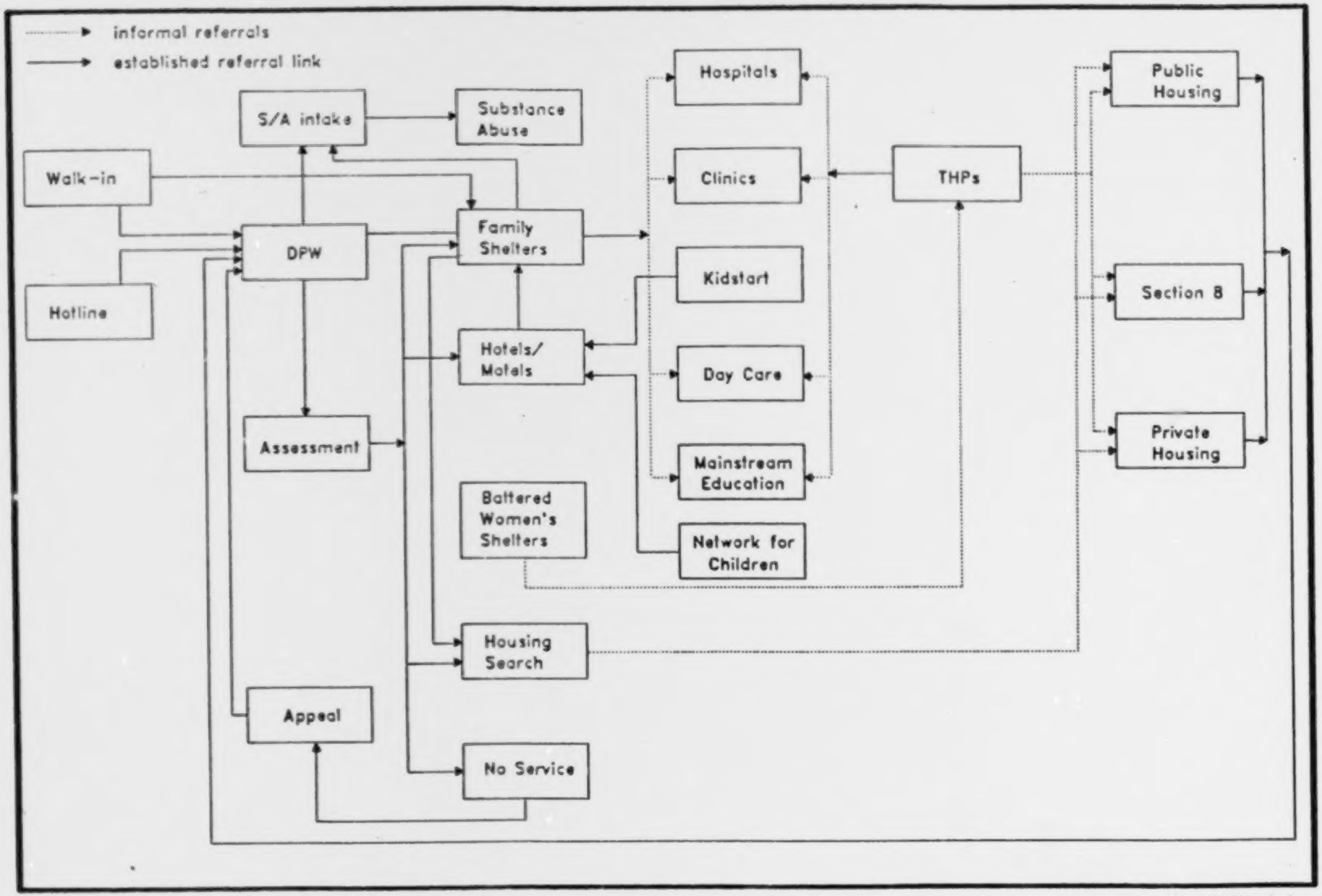
EXHIBIT 1

DESCRIPTION OF SITE VISIT PARTICIPANTS: BOSTON

Program Name	Organization Type	Services	Toured Facility
Greater Boston Legal Services	Advocacy	Legal representation on individual and class action suits	
Fund for the Homeless	Advocacy and Funding	Organization and funding of coalitions and advocacy organizations	
Massachusetts Coalition for the Homeless	Advocacy	Coordination and advocacy for homeless services	
Salvation Army Day Care Center	Child Care Center	Drop-in child care for homeless women with children in Cambridge shelters	X
Women, Inc.	Shelter	Emergency shelter, transitional housing services	X
Kidstart	Health Program	Mobile health care and screening for homeless families in hotels/motels	X
Massachusetts Shelter Providers' Association	Advocacy and Coordination	Coordination of shelter and transitional housing providers	
Network for Children	Advocacy and Social Services	Information and referral, support groups for homeless families in hotels and motels	X
Cambridge Multi-Service Center	Social Services	One-stop shopping for support services, primarily housing services	X
Medford Family Life	Transitional Housing Program	Transitional housing and services for homeless women with children	X
McKinney Coordinator, State Department of Education	State Office	Oversight of school access and choice provisions of McKinney Act	X
State Executive Office of Communities and Development	State Office	Oversight of Section 8 and state public housing programs	
State Department of Public Welfare	State Office	Reimbursement of shelters, issuance of shelter vouchers, housing search counseling	
Emergency Shelter Commission	City Office	Oversight of city's efforts related to homelessness	

EXHIBIT 2

FLOW OF CLIENTS THROUGH THE SERVICE SYSTEM: BOSTON


informal referrals
established referral link
S/A intake
Substance Abuse
Walk-in
Hotline
DPW
Family Shelters
Hotels/ Motels
Assessment
Battered Women's Shelters
Housing Search
Appeal
No Service
Hospitals
Clinics
Kidstart
Day Care
Mainstream Education
Network for Children
THPs
Public Housing
Section 8
Private Housing

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A. Size and Characteristics of the Population

Data on the characteristics of the homeless population were secured from a variety of sources. The Comprehensive Homeless Assistance Plan (CHAP) indicates that there were 10,000 homeless people statewide in 1989. The estimate of the Massachusetts Coalition for the Homeless is higher--24,000 homeless individuals statewide. The most recent single-night census conducted by the Emergency Shelter Commission in December 1990 found 3,613 homeless individuals in Boston.

The proportion of families in the total homeless population in Boston varies by source. The CHAP, citing a figure from the State Executive Office of Human Services (EOHS), estimates that 75 percent of all homeless individuals statewide are members of homeless families. This is far higher than in the other cities visited for this study. However, of all homeless sheltered individuals counted in the 1990 single-night census by the Emergency Shelter Commission, 19 percent were members of homeless families.

The homeless family population in Boston is represented disproportionately by African-Americans and female-headed households.

Recidivism data are scarse. One EOHS study of homeless individuals who were placed in permanent housing (including private, public, or subsidized housing) found that 9 percent returned to the homeless service system. This study was conducted over a 2 year period. Information for homeless families was not tracked separately.

The number of homeless families in emergency shelters has declined markedly during the last few years. At one time, there were as many as 1,200 families in the State's emergency shelter system, 700 of these were housed in hotel/motel situations because the capacity of the emergency shelters had been exceeded. Currently, there are 500 to 600 families in shelters; in December 1990, the Emergency Shelter Commission census found only 100 individuals with vouchers for hotels or motels. There is considerable controversy in Massachusetts about the reasons for this decline. Many maintain that the new State assessment program diverts people from shelters to other services such as housing search assistance; advocates believe that the State funding crisis has led to either new eligibility criteria or stricter enforcement of existing criteria and that many families who request shelter are denied or discouraged.

Although the State Department of Public Welfare (DPW) encourages the shelters to accept them, intact families and families with older children have tended to be placed in hotels/motels rather than shelters. However, the decline in the use of DPW hotel vouchers may change that.

B. Factors Related to Family Homelessness

Data on the factors related to homelessness were acquired in interviews with providers and advocates, from national data sources, and from local data collected by the Massachusetts Coalition for the Homeless.

Economic or Structural. Clearly, all informants agree that the dearth of affordable housing is the major cause of family homelessness in Boston. The escalation of housing costs in New England is known nationally; the pinch is felt into the middle class. Since 1980, Boston areas rents have increased by 64 percent. While the State has done a thorough job of attracting and keeping in circulation Section 8 certificates and other subsidized housing options, most housing for the low-income population is unsubsidized and, given market rents, many households must pay far more than the threshold of 50 percent of their income which accords preference to subsidized housing programs. Even though Massachusetts' income maintenance benefit levels are comparatively high, the gap between benefit levels and fair market rents is among the largest in the Nation---fair market rent (FMR) consumes nearly three-quarters of the benefits.

Unemployment is a second widely acknowledged cause of family homelessness. After a decade of economic boom, Boston and the New England area in general are in the midst of a very deep recession. Unemployment is higher than the national average, after nearly 10 years of almost full employment. The shift from a manufacturing to service-based economy occurred earlier in New England than in the rest of the Nation, and the decline in major industries has left an excess of low-paying service jobs.

Because the affordability crisis is more salient in Boston than in our other cities, advocates were more inclined to cite Federal housing policy as a contributing factor in family homelessness. Advocates believe that the Federal government retreated from its commitment to ensuring a supply of affordable housing. Health and human services (HHS) agencies are left to pick up the pieces and fill in the gaps with services that are not necessarily cost effective. Some contend that the money put into providing emergency shelter and services would be better spent for rehabilitating substandard housing and rent subsidies, but neither of these are acceptable uses of HHS money since the agency resists the pressure to become the "house of last resort."

Although affordable housing is a major problem in the Boston area, in outlying areas such as Lynn and Fall River, affordable private housing is still a possibility. Consequently, and unlike other cities, efforts are often made to relocate homeless families to other cities in the State where housing is more affordable.

Individual Factors. To a greater extent than in most of the cities visited, advocates and providers were reluctant to attribute family homelessness to individual problems such as substance abuse and mental illness. In part, this reflects a dominant ideology among service providers of homelessness as a failure of the system. In addition, the decline in the economy and the escalation of housing costs have clearly put a larger portion of households at risk of homelessness. A survey of public attitudes towards the homeless indicated that 57 percent of respondents were sympathetic to the plight of homeless people because they felt that their own households were at risk of homelessness.

Nevertheless, providers do talk about individual factors that contribute to homelessness. The most frequently mentioned is substance use. Until very recently, there were few treatment centers able to accommodate women with children. The State has recently opened a statewide network of shelters for women needing substance use treatment, although there is controversy over the way these programs are funded and the level of services to be provided.

Mental illness is a prominent issue in homelessness, but is more commonly mentioned as a cause for single adults. The Mayor is participating in a class action suit against the State Department of Mental Health regarding the inappropriate discharge of institutionalized mental patients to the community. Many former patients end up in the largest homeless shelters in Boston.

Family violence is often mentioned as a factor that precipitates the loss of housing. Some advocates indicated that most of their programs' participants had a history of abuse, however, others indicated that a recent study shows that the incidence of violence is no higher among homeless women than among low-income housed women. There is a separate system of battered womens' shelters, but these are funded separately from the family shelters and interact with a different State agency.

C. Development of a Response to the Problem of Homeless Families

Most informants trace the rise in prominence of family homelessness as an issue on the public agenda to a 1983 initiative by the Dukakis administration, which declared homelessness its number one priority. The initiative was developed under the direction of an advisory committee. Its hallmarks were an emphasis on using mainstream services, the recognition of housing as the key need, acknowledging the need for prevention, and a commitment to small, home-like family shelters.

Initially, the response took the form of providing emergency shelter for families while permanent housing was being sought. Two shelters were funded in the State to provide emergency services. The emergency shelter system has since grown to a network of 100 shelters, of which 60 to 70 are for families.

While many other actions since 1983 have shaped the response to family homelessness in Boston, the recent cutbacks have been most important. The Dukakis 1983 initiative raised expectations about a "big-picture" approach to homelessness. Many advocates, some of whom had gone to work for the administration, felt betrayed by the government's cutbacks. The public climate has soured and made Boston the most litigious of the cities visited for this project. These issues are discussed further below.

Advocacy is more visible and aggressive in Boston than in the other cities. There are ongoing legal challenges to denial of shelter and class action suits on public housing issues. These have all helped to shape the current service system.

D. Political and Social Climate

In terms of the number of political actors in the system, Boston is the simplest of all the cities visited. The human services system in Massachusetts is State-administered. Although a county government structure exists, counties (Boston is part of Suffolk County) have almost no responsibilities related to human services. The city government, while actively involved in homeless issues, is focused on services to single homeless individuals. Because most homeless families interact with the State-administered income maintenance and social services system, it has made sense to assign to the State the primary role in providing services for homeless families.

During the early Dukakis years, relations among providers, advocates, and government were very cordial. Government was seen as a partner on the issue of homelessness, and many advocates entered government to work for the administration. The sheltering system was an open one, and anyone who self-declared homelessness was sheltered with little or no entrance criteria.

The recent strain in government and advocacy group relations is attributed to the budget crisis that began in FY 1989 and brought major budget cuts in 1990 and 1991. Many advocates do not feel that the cuts in homeless services were justified. Moreover, the number of families in shelters and motels has decreased markedly, which advocates attribute not to the State's underfunded prevention efforts, but to stricter eligibility rules. The Governorship changed political parties in the last election; this has created additional uncertainty about the future.

According to advocates, the business community is considered generally supportive of efforts on behalf of homeless families and has been generous in terms of financial and volunteer contributions. Informants also indicated that charitable giving has tended to increase in categories related to homeless. The city is not experiencing the backlash against homelessness that is being predicted nationally. A recent study of public attitudes, conducted by the Fund for the Homeless, indicated that the public was generally sympathetic to the plight of homeless people, could see themselves in the homeless category (perhaps because of the precariousness of the current economy now), and were willing to raise taxes to provide housing. Advocates suggest that the recession has led to more understanding of homeless people because so much of the middle class is being affected by economic issues. More than half of the respondents (57 percent) felt they were in danger of becoming homeless themselves, and most attributed the cause of family homelessness to lack of affordable housing and growing unemployment.

IV. System Coordination Efforts

Boston has a number of system initiatives at the government agency, service provider, and individual family levels that contribute to coordinated service delivery to homeless families with children.

A. Coordination Efforts at the Agency Level

Agency coordination, while important, is less of an issue in the emergency shelter system in Boston than in our other site visit cities. The system centers on the State Department of Public Welfare (DPW), the lead State agency for providing services to homeless families. It provides AFDC benefits, Emergency Assistance (EA) and reimbursement to shelters under a voucher system.

DPW works with the Department of Social Services (DSS), which operates some specialized homeless services and shelters under contract, including the battered women's shelters. Most importantly, DSS, at DPW direction, also performs the assessments of those seeking emergency shelter or housing assistance. DPW also interacts with the Department of Mental Health (DMH), the Department of Public Health (DPH), and the Executive Office of Community Development (EOCD), which oversees capital development, the State rental subsidy program, and coordinates public housing and the Section 8 program, which are mainly administered through a system of 250 local housing authorities.

Although there is supposed to be interagency coordination among these State agencies, site visit informants indicate that the lack of resources and resulting pressures has led to some avoidance of responsibility for services to the homeless.

One prominent attempt to coordinate agency efforts was the State-funded transitional housing program. EOCD set aside some Section 8 certificates for project-related subsidies and worked with DSS to write a joint request for proposal (RFP) that would integrate social services with the housing component. This was an innovative effort, but was plagued with problems such as different grant cycles and agency requirements.

B. Coordination Efforts at the Provider Level

The service system in Boston is considered fragmented according to site visit informants, although both the funding and intake system are more centralized than in other cities.

While several homeless-related coalitions exist in the Boston area, we identified none specifically concerned with family homelessness issues. A group with State, city, and community organization representation was brought together to respond to the RFP for the Robert Wood Johnson Foundation Family Homeless Program, but it has not continued to operate as a group since that effort.

The Massachusetts Coalition for the Homeless is the broadest and most visible coalition and includes statewide representation of providers and advocates. The Coalition provides advocacy related to housing and income issues and also provides some direct services, including a DOL/McKinney-funded job training project in collaboration with My Sister's Place, a local women's shelter, and coordinates donations to the furniture bank.

The Massachusetts Shelter Providers Association (MSPA) represents provider issues; family homeless shelters are one of the constituent committees of this organization. MSPA began as an informal group in 1983, then incorporated in 1986. In 1989 they received a $75,000 grant from the Fund for the Homeless to support two staff members and to assume the Fund's technical assistance functions. The Association conducts annual conferences and awards technical assistance funding once a year for peer consulting for shelters.

While not specifically a coalition, the Fund for the Homeless is an organization with strong ties to the advocacy and provider community. The role of the Fund, which obtains its funding from the Boston Foundation, public donations, and other foundations, has evolved over time. Currently, it serves two functions related to collaboration among providers and advocates. The Fund convenes groups and provides funding for advocacy activities; they are working to develop a common agenda among advocates on housing issues, income issues, and social services issues. This is innovative because housing coalitions and welfare coalitions have rarely pursued joint agendas. The Fund also acts as the regional director of the Homelessness Information Exchange--a regional clearinghouse and information forum.

A consistent theme of using mainstream service systems was evident in Boston. Many providers, advocates, and State officials articulated a strongly held philosophy of not duplicating services by creating a specialized service system for the homeless. The State purposely has restricted the amount of reimbursement for shelter social services staff to one "family advocate" whose role is to provide referral and case management for mainstream services.

C. Coordination Efforts at the Family Level

There does not appear to be systemwide coordinated case planning/management in Boston. Initially, DPW envisioned a case-managed system and planned to assign a DSS worker to serve as case manager for each homeless family after the assessment process was completed. However, this system was never effectively implemented because the overwhelming demands on DSS staff have forced them to focus their resources only on families with special needs (i.e. CPS, mental health).

Shelters funded by DPW are required to include a "family life advocate" as part of their staff. Their role is to assist families in improving life skills and in making linkages to needed community resources according to individualized plans. Some informants indicated that the quality of these services vary among the shelters. As a result, case management may not always be provided on a routine basis, but happens periodically for some portion of the population and tends to be spurred on by events like evictions from shelters, eligibility expiration, or missed appointments.

We identified two programs that have expanded their roles to encompass case management services to families in hotels and motels. The Kidstart program of Boston Children's Hospital provides mainly developmental and health services for families in Boston area hotels/motels, but also assumes some case management functions. The Network for Children, a program offering support groups and information and referral, targets families in hotels and motels in the Malden area. It should be noted that both of these programs have experienced declining client populations as DPW reduces the number of families placed in hotels and motels.

A multiservice center coordinated by the city of Cambridge's Department of Human Services attempts to fill similar functions for homeless families in Cambridge. However, most of the services relate to housing, and the center has been unable to realize the full extent of its original one stop shopping goal. While several providers have offices in the building, of the relevant State agencies, only DMH has staff in the building.

Follow-up is a bit more extensive in Boston programs than in those of other cities visited, although the extent of the follow-up varies. All three housing programs visited--all of which were selected because they were exemplary in some way--had follow-up components which included, among other approaches, continued availability of services to program graduates, regular group sessions for program graduates, and home visits within a specified period of time after the client leaves the program. All programs reported good rates of participation in these programs, and it is not uncommon for a graduate to become one of the program staff.

It is not clear why follow-up is more fully developed in Boston than in other cities visited. One factor may be that the longer shelter stays--up to 90 days, or longer--permit the program to develop a stronger bond with the participants so that they are more willing to be "followed" than participants in other cities.

V. System Comprehensiveness

This section presents the service system components and describes how each addresses the needs of homeless families. Within each component is a description of the primary service providers or actors, how services are provided, their comprehensiveness, capacity, and barriers and gaps in service delivery. It should be noted that the following comments are general impressions based on interviews with a limited number of government agency representatives, service providers and advocates.

A. Housing Continuum for Homeless Families

Emergency Shelter. At the core of the housing continuum for homeless families is a statewide system of 60 to 70 family shelters. Shelters are open year-round, 24 hours a day. They are deliberately designed to be small (typically 8 to 12 families); the smaller facilities are often located in renovated large victorian style single-family dwellings. The total capacity is 596 families. Shelters are reimbursed by the State on a per diem basis. The State, in turn, submits its costs for reimbursement through AFDC-Emergency Assistance (EA) funding. There are approximately 10 family shelters that are privately run and receive no State funding. Additional networks of substance abuse shelters and battered women shelters also have a role in housing homeless families. The substance abuse shelters are part of the DPW system, while the battered womens' shelters (approximately 34 shelters) are funded through DSS contracts.

AFDC-EA covers up to 90 days of emergency shelter and the first month's rent and deposit (or last month's rent). Other expenses covered include day care and transportation costs incurred while locating housing; a nutritional allowance if food stamps had been cut while in shelter; moving expenses; furniture storage, and utility, rent and damage claims arrearages.

EA benefits can be used only once in a 12 month period. The State will grant waivers to extend the shelter portion of EA benefits for stays that exceed 90 days on a case-by-case basis; however, some advocates report that the State is becoming stricter about granting waivers.

The 90-day length-of-stay shelter system serves both an emergency and transitional housing function. While the average LOS is 72 days, providers report that longer stays are becoming more and more common. Some informants feel that the nature of the homeless family population has changed, that families are becoming more dysfunctional and need more than a 90-day shelter can provide. Others strongly disagree and feel that intensive services are not needed.

Access to the shelter system is centralized in terms of criteria for services. Families enter shelters through local DPW offices, and DSS caseworkers conduct a DPW-designed health and safety assessment to determine needs and assign prioritization for shelter. The health and safety assessment is designed to look at medical needs, school, family, abuse/neglect, and physical space. The assessment results in one of three priorities for services: (1) immediate shelter/housing placement; (2) "at-risk," in need of housing search services; and (3) housing not currently an issue.

Shelters are "buddied" with one to two local DPW offices for referral purposes. Some shelters have some discretionary beds, but most must get referrals from the State. DPW reimbursement to shelters includes funding for a housing advocate, who helps residents with their housing search, and a family life advocate, who provides skills training and helps families become linked to needed services. Hiring and specific role definitions are left to the discretion of the shelters. Additional program staffing must be funded by the shelter through philanthropic contributions and grants. Shelter rules and expectations of participation in services vary from shelter to shelter.

Availability of shelter space is restricted for large families (i.e. more than three children) and for families with male children over the age of 12. Few shelters have enough space to accommodate large families, and some fear potential problems with older boys, especially in situations where bathrooms and living quarters are shared. The family shelter visited--Project Hope--does not have any age restrictions; they have housed families with older boys and have not experienced any problems.

If shelter beds are not available--because shelters are full, the family is too large, or the family has male children older than 12 years--then the family receives State vouchers for hotel or motel housing. Families evicted from shelters because of rules violations are also housed in hotels/motels.

Families in hotels/motels do not have access to the range of services provided by many of the shelters. Ironically, some informants indicated that these families tend to be more dysfunctional than their counterparts in shelters and the population most in need of services. The site visit team identified two efforts to fill this service void--Kidstart and Network for Children, both of which are pending refunding. The number of families housed in hotels/motels has decreased sharply from 700 one year ago to 100 statewide, and 20 in Boston. Site visit informants expect these numbers to continue to dwindle. Advocates report that the primary reason for the decline is stricter applications of the criteria under the DPW assessment process. The wide-spread public outcry against "welfare hotels" may also play a part in DPW's reluctance to continue to place families in such facilities.

The assessment process has been controversial among advocates and providers. DPW characterizes it as a way to provide prevention and target services. Prior to creation of the assessment process, a family had to be homeless (i.e., go through the emergency shelter system) to receive housing assistance. The assessment process makes it possible to identify families in need of housing assistance before they become homeless. Advocacy groups contend that the process gives the State gatekeeping power and keeps families from receiving shelter. They view the decrease in families in hotels and motels over the last year as an indication that more families are being screened out of the system and fewer of those in need are being served. There is also concern that because DSS, is doing the assessments, (the State agency with the power to remove children from parents' custody), many families are not presenting themselves for services.

Transitional Housing Programs (THP). In the late 1980s, when it became clear that some families needed more intensive help to maintain independent permanent housing, the State began to develop some transitional housing programs for special populations such as pregnant teens, battered women, and homeless people who needed more intensive help.

The funding stream for transitional housing programs is much more complicated than for shelters. The key is project-based Section 8 and State Chapter 707 Certificates. These assure a dependable (10 year) income stream that allows the provider to obtain access to conventional sources of permanent financing. The Section 8 commitment is packaged with EOCD grant funds and a DSS contract. The DSS-EOCD link innovation required lobbying of joint funds from the legislature and a joint RFP to ensure a link between social services and housing.

THPs typically have stricter criteria for program admission and lengths of stay from 12 to 18 months. They are not part of the DPW placement system and assessment process. Referrals theoretically may come from shelters, but no formal system links the two systems. The programs visited drew few participants from shelters.

Transitional housing is a controversial concept in Boston. Some advocates oppose it as another step in the system that requires unnecessary commitments from clients and consumes funds that could be better spent on permanent housing. Others believe that there is a segment (and it is increasing) of the homeless family population with severe dysfunction who require the intensiveness of this setting.

Many advocates favor transitional services rather than transitional housing. Given the limited resources for affordable housing and the sense by some advocates that only a very small number need intensive services, there is opposition to creating a special housing setting, mandating services, and then after a period of time pushing the family out of the setting and back into the housing market.

Permanent Housing. The State-aided public housing program has 48,000 public housing units which the State has paid for, plus 20,000 units in a rental assistance program linked to Section 8. These programs are administered through a network of local public housing authorities, although some Section 8 and Chapter 707 assistance is controlled by the State.

Despite the size of the public and subsidized housing system, public housing is considered a minute resource for homeless families. Site visit informants estimated that only 2 percent of homeless families are eventually successfully referred to public housing. Homeless persons do receive priority for both the State Chapter 707 subsidy program and the State-controlled Section 8 certificates. But the vast majority of public housing and Section 8 certificates are under local housing authority (LHA) control. The LHAs have considerable autonomy; the differences in priorities and application processes tend to limit access by homeless families.

Because affordable housing is seen as the major cause of family homelessness, Massachusetts has been more progressive than most in developing programs to address permanent housing issues. Although conceptually sound, these programs were never fully implemented because of budget cuts.

The budget crisis resulted in almost no funding for the Chapter 707 rental subsidy component of the State's prevention program; however, the assessment process survived as a method for screening shelter applicants, as did the housing search program component.

The housing search program is staffed with counselors who maintain lists of public and private landlords throughout the State. In the last few years, the role of the counselors has changed. In the past, it was not hard to obtain subsidy, but it was difficult to convince landlords to accept subsidized renters;the efforts of counselors were focused on recruiting landlords. Now, as vacancy rates increase and some market rents drop to near the Federal Fair Market Rent level, the subsidy is attractive to landlords and the efforts of counselors focus on finding subsidies. Housing regulations allow people to apply for Section 8 assistance in any LHA and to use the certificate in any Section 8 unit in the State. The counselors' primary role has become to assist the family with the application process and to match the family with the specific LHA priorities. There are as many as 250 housing agencies statewide, with 250 application procedures and priorities. The State spends an estimated $1,300 per family on the housing search program. Critics believe that this expense would be unnecessary if the housing application process were centralized.

Because the supply of private affordable housing is somewhat larger outside of the Boston metropolitan area, some counselors have concentrated on moving homeless families to new cities. Boston was the only city visited where relocation of homeless families was pursued as an option.

In the opinion of some advocates, the high cost of housing, the new assessment criteria, and benefit eligibility interact. Many advocates believe that the housing search process cannot work because there is insufficient affordable housing. Counselors can use AFDC-EA funding to move a family into permanent housing, but once EA runs out (in the second month), the family cannot afford the rent. If families are evicted from unaffordable housing or leave substandard housing they have exhausted their EA eligibility. Yet that eligibility is their access to further housing search services.

B. Health and Developmental Services

Developmental Services. The Boston public school system offers a special education program for developmentally delayed children age 3 and older. Site visit informants indicate that the evaluation and enrollment process is time consuming and complicated--it has taken as long as 6 months for some children to get into the program. Barriers to access include long waiting lists for the core evaluation that must be conducted by the school system, requirements for a stable address, and the development of an individualized education plan which can be a lengthy process requiring multiple meetings with the parents. Kidstart at Boston Children's Hospital was providing initial screening for developmental delays in children age 3 to 6 years who were residing in hotels/motels. Contingent on continued funding, the program plans to offer the same services to sheltered families. The Medford Transitional Housing Program also conducts developmental screening.

Health Services. Massachusetts' health care system is characterized by a strong network of neighborhood health centers. Contingent on continued funding, the program plans to offer the same type of developmental screening and referral services to sheltered families. Site visit informants indicate that when asked, virtually every homeless family can identify a primary care physician. This is in marked contrast to other cities visited.

Boston also has a Health Care for the Homeless (HCH) project, originally funded by Robert Wood Johnson (RWJ) and now funded by Federal McKinney Act monies. The HCH's function is to help ensure that homeless families maintain ties to their neighborhood health centers; HCH does not intend to duplicate the health centers' service. HCH will provide immunizations, if needed; encourage or facilitate well-child care; and serve as outreach workers for the health centers, for example, providing cab vouchers so families can get transportation to the centers.

The exception to the health care center affiliation is for families within a one square-mile area that houses seven major teaching hospitals. For this area, HCH holds primary care adult clinics 4 days per week (two at Boston City Hospital and one each at Massachusetts General and New England Medical Center) and a pediatric clinic 1 day per week at Boston City Hospital.

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C. Education

Massachusetts public schools provide free preschool programs for children determined to be developmentally delayed. The Kidstart program provides initial testing and screening to identify developmentally delayed preschoolers and to get them into this program. Kidstart also attempts to link families with other needed services.

No Head Start programs are dedicated to serving homeless children. Developmental screening for children age 3 to 6 is available, but Head Start programs are reported to have very long waiting lists, which significantly limits their accessibility. Providers also indicated that homeless families need more than just half-day programs, which is the typical Head Start offering in the Boston area.

According to policy of the Massachusetts Department of Education, parents have the right to decide where their children will attend school; however, the policy is not backed by statewide support for transportation. This issue is left to local school district initiative. Currently, the Boston school district is progressive about ensuring the right to attend the school of origin. The interim superintendent has assigned a liaison person who serves a troubleshooting function. The Boston school district supports transportation and has modified the bus system to transport homeless children to schools of choice, this is facilitated by the relatively small size of Boston's school district.

This comprehensive busing system, originally developed to ensure racial balance, can easily accommodate transporting homeless children across town from shelter to home school. At the core of this system is a network of parent information centers in each of four Boston zones which assist families in identifying the schools of choice and transportation options. Boston also has a magnet school system, which is considered an ideal option for homeless children since it provides continuity regardless of the transiency of the family. Providers report that they try to encourage homeless families to enroll their children in the magnet system.

Boston maintains attendance data for homeless children; at one time there was a 17 percent nonattendance rate for homeless children, but since efforts of the McKinney coordinator and advocates to eliminate barriers to enrollment, that figure has dropped to 13 percent. Major barriers were created by the requirements for documentation of residence, immunizations, and lead-paint screening. Now, a letter from the shelter is sufficient proof of residence. Also, parents no longer are required to show immunization records and lead-paint screening to enroll their children; it is now permissible for schools to call and obtain this information over the telephone.

To set up a tracking system to help ensure that homeless children are in school, the McKinney coordinator held a conference for shelter providers, schools, and social service providers to discuss this and other homeless issues. Shelter providers resist the concept of a tracking system for reasons of confidentiality. Another unresolved issue related to confidentiality is whether the identity of homeless children should be known to the teachers. The teachers feel that in order to assist homeless children, they need to know who they are.

Shelter providers feel that confidentiality should not be breached and that it is unnecessary to label the children as homeless.

Center staff have been trained to assist with outreach; however, some still misunderstand which documents are absolutely necessary to be enrolled and which can be submitted later. The coordinator believes that there are still some shelters that are not fully aware of the issues and the mechanisms in place to get around some of the problems.

Some of the other remaining barriers to access and choice include transportation (to some extent), and record transfer from other States. Lack of parent cooperation is seen as a barrier by some; parents are convinced that the length of stay in the shelter will be short and do not bother to send the child to school.

D. Child Care

Affordable child care was identified by many of the site visit informants as a major obstacle to self-sufficiency. There are State subsidies for qualified applicants through a voucher system, but in the current budget climate the vouchers are virtually nonexistent.
Boston does not have a dedicated child care system for homeless children, although, some child care centers serve homeless children. Also, some shelters provide day care on-site, and two of the programs visited were using a State DSS mechanism to reimburse for cooperative babysitting arrangements. However, in general, the availability of affordable child care for mothers while they were in shelter was worse in Boston than in any of the cities visited for this project.

E. Other Support Services

Support services such as training for life-skills, parenting skills, and individual adult and child counseling are available to varying degrees. The DPW Family Life Advocate positions are expected to provide these services; however, the degree to which shelters include these services as integral components of their program varies.

Depending on the philosophy and focus of the shelters, psychosocial support and life-skills training are either simply made available or are requirements for receiving shelter. Transitional housing programs are more likely to have required services. Support services were key components of all THPs that were visited in the Boston area.

F. Employment and Training

Access to employment counseling and training programs depends on the shelter. Shelters visited emphasized the importance of helping families develop education/employment goals and had established linkages to GED and training programs. Some providers emphasize education over employment because they feel that with employment, benefits are stopped and the prohibitive cost of housing and child care cannot be covered by the low paying jobs these families are most likely to get. By pursuing education, parents are laying the groundwork for obtaining better jobs when the children are old enough to be in school.

Several informants indicated that traditional employment programs such as JTPA tended to be inaccessible to homeless mothers with children. Reimbursement to providers of employment services includes incentives to place workers who can command higher salaries--$6.90 per hour was cited by one informant--than the training and skills of the average homeless mother on AFDC are likely to command. "Creaming" by these programs tends to exclude most homeless mothers.

G. Other Program Linkages

Child Welfare and Protective Services. Homelessness is not considered an automatic reason to take children into protective custody in Massachusetts. However, it is a CPS policy to deny reunification of children who are already in custody if the parent is homeless.

Some of the persons interviewed raised some concerns about the negative effects CPS can have on homeless families. If the child is removed from the mother while in shelter, the AFDC grant can be terminated and a disastrous downward spiral begins: the mother will be sent to adult shelters which are nighttime shelters only' she then has no suitable place to visit with her children, which is one of the prerequisites for reunification; and she has less access to some of the case management services that would assist her in making reunification possible.

Entitlement System. Site visit informants indicated that the vast majority (95 percent) of shelter clients are already receiving AFDC. According to the staff of the shelters visited, most of their clients are also already receiving WIC benefits. Determination of benefits is typically included in the intake process. The best functioning shelters with more comprehensive services have social workers on staff who help families make these linkages, if needed.

Substance Abuse Service System. Drug abuse was identified as a big problem by providers; it often leads to eviction from shelter. The greatest obstacles to treatment, according to those interviewed, were a severe shortage of treatment beds (only 17 statewide) and the disincentive for mothers to participate because of the fear of being separated from their children and possibly losing AFDC benefits.

The State DPW recently funded ten substance abuse shelters statewide. They are designed as 9-month transitional programs for women who have gone through detoxification and their families. There will be a separate entry system for these shelters. Not all of these shelters are up and running yet, but will be soon. Some advocates fear that people will be inappropriately or punitively placed in these shelters if they want to access to housing services, but others see the shelters as a positive and necessary development.

Mental Health Service System. Links between the shelter system and the mental health system were not explored. While premature discharge from State institutions was a major factor in homelessness among single men and women, it was not cited as a factor in family homelessness.

Domestic Violence Service System. The State has a network of 34 battered women's shelters that are funded separately through DSS. Although women in these shelters are counted among the homeless, they are not connected to the homeless shelter system. The State's level of support for this system of shelters is much lower than for the homeless shelter system.

VI. General Issues and Barriers Related to Service Comprehensiveness

Boston's response to the problem of family homelessness has some identified strengths as well as service gaps and other barriers to a comprehensive and coordinated service system. Following is a summary of the major strengths and barriers that were consistently mentioned among several of the site visit informants, and observed by the site visit team.

A. Strengths and Innovative Efforts

Massachusetts has undertaken many conceptually sound innovations, some of which have been derailed by the current budget crisis.

- The State rental subsidy program would have addressed prevention of homelessness to a far greater extent than efforts in other cities we visited, but was never fully funded.

- The central DPW intake and reimbursement process contains the skeleton of a centralized case management system. But funds to finance this system are insufficient.

- The housing assistance program is far more extensive than anything available in the other cities we visited. However, it has been reduced to an application assistance process because of the tangle of local LHAs with differing application processes and the general unavailability of affordable housing.

- The state's commitment to small, home-like family shelters, the extended length of stay and the provision of family life advocates and housing search assistance allows emergency shelters to provide a broader range of services than in any other city visited. Shelters in Boston resemble THP's in many of the other cities--especially if the shelter has undertaken to develop social service linkages beyond those reimbursed by DPW.

- There appear to be more follow-up services in Boston than in other cities we visited.

- Public attitudes are sympathetic to homeless families.

The State DSS assessment process may have been conceptually sound in that it permitted the State to define need for housing more broadly than the need for emergency shelter and would have permitted services for at-risk, as well as homeless families. However, State officials concede that its original purpose was prevented by the lack of funds. Some advocates and providers contend that the assessment process was never intended to reach the at-risk, but instead was developed as a means to restrict shelter access.

B. System Gaps and Barriers

Gaps and barriers in Boston resemble those in all of the cities we visited; however, the economic recession has tended to exacerbate some of them.

Affordable housing is the major obstacle to self-sufficiency, as it is in all cities. However, the escalated housing market makes the problem that much worse in Boston.

The demise of the State 707 program and the decentralized nature of the Section 8 system, with 250 or more local jurisdictions, are barriers to obtaining access to the publicly-funded affordable housing that exists.

Although the capability for case management appears to be present at the shelter level, there is no coordinated linkage of housing and social services as the family moves further along the housing continuum.

The involvement of DSS in conducting the housing assessments is seen as a barrier to participation by families whose only prior contact with the agency was through Child Protective Services (CPS) and who therefore fear the loss of their children to the foster care system.

Affordable child care is a serious gap in the family homeless service system in Boston and in all cities. Few subsidized options in Massachusetts are in a position to add clients; the few options available to sheltered mothers disappear once they leave the emergency shelter system.

Some informants indicated that working poor mothers were at a disadvantage in gaining access to a shelter. Because the shelter system is reimbursed through AFDC-EA, there may be a built-in preference for those who are AFDC eligible. This may exclude the working poor who make too much for welfare but not enough for affordable housing and thus get squeezed out of both systems.

Many advocates believe that the "emergency" shelter system is becoming institutionalized because of the lack of affordable housing. They think that, while the shelters are effective, they have ceased to be a transitory solution and have become "homes."

Program Profiles

Boston, Massachusetts

Health Care for the Homeless

Organizational Issues

The Boston Health Care for the Homeless (HCH) project is coordinated out of Boston City Hospital and began operations in 1985 with a 4-year Robert Wood Johnson Health Care for the Homeless grant and matching funds from the State. The goal of the program is to provide quality health care to homeless individuals and families.

Teams of health care practitioners holds clinics in 45 Boston area shelters on a regular basis. Of these, 14 are family shelters and battered women shelters. They also go to 11 of the Boston area hotels/motels. Clinics are held five times weekly at the larger adult shelters and once every other week at the smaller family shelters.

The family team is comprised of a pediatrician, two nurse practitioners, MCH nurses, and family advocates. Clinics are attended by physicians, nurses, and caseworkers.

Points of Entry

Patients access services through the regularly scheduled clinics in Boston area shelters and three area hospitals.

Service Delivery

The HCH family program views its roles as primarily screening and referral. They try to encourage people to maintain relationships with the strong network of community neighborhood clinics in the Boston area. When asked, most homeless families are able to identify a neighborhood health center as their primary health care provider. However, some primary health care services are provided by HCH, for example immunizations, depending on the needs of the individual. In addition, HCH staff conducts rounds on any homeless person who is an inpatient at one of the area hospitals; it is important for them to have input on discharge planning.

HCH staff report that families in hotels/motels typically suffer from more health problems and require much more episodic care than their counterparts in the shelters.

HCH runs clinics 4 days per week for the homeless adults and one day a week for pediatric patients at Boston City Hospital. In addition, adult clinics are held once a week at Massachusetts General Hospital and at New England Medical Center.

HCH has worked hard to build relationships with the network of neighborhood health centers. Early in the program, they contacted the League of Community Health Centers to identify contact persons and to help them understand the nature of their program and allay any fears about service duplication.

There is no limit to the duration of services; however, access to clinics is linked to shelter and hotel/motel residency which generally is around 90 days.

Coordination and Effectiveness of Services

HCH completes a "contact sheet" for each person that is seen. These are kept in a central record at the HCH offices as well as by the individual families. This helps to ensure the continuity of care.

They try to assist people with their needs as they arise and have three social workers on staff to fulfill this role.

Effectiveness of the HCH family program is tracked only in terms of process outcomes. Followup is difficult once families leave the shelter or motel, however neighborhood health centers do followup.

Financial Issues

The current funding level is $1.7 million including $450,000 from State sources, $750,000 from McKinney funds, $100-200,000 from Comic Relief, and the remainder from foundations and fundraising. HCH is now an approved Medicaid provider.

Staffing

HCH staff include 5.5 FTE physicians (one of whom has half-time research responsibilities at Massachusetts General Hospital, 6.0 FTE nurse practitioners, .5 FTE dentist (need another .5), .5 FTE dental hygienist, 1 public health nurse, 3 adult caseworkers, 3 family advocates (caseworkers).

HCH has not experienced any problems with staff turn-over. In fact, the initial expectation of 1 year tenures has been exceeded; some staff have stayed as long as 3 to 5 years.

Barriers and Issues Identified

HCH staff report that substance abuse and chronic mental illness are big problems among the homeless population and that there are not currently enough services to deal with these issues. Another problem that was cited was the lack of transportation. Public transportation is very difficult for mothers with small children.

Project Hope

Organizational Issues

Project Hope is a small family shelter located in the north Dorcester/Roxbury community. It is located in a renovated single-family dwelling and is sponsored by the Little Sisters of the Assumption, who have been serving low-income members of this community since 1948.

Project Hope has been operating as a shelter since 1981 and was one of the first shelters funded by the Department of Public Welfare (DPW) under the Dukakis Homeless initiative. It is considered the best example of a family shelter program in Boston and served as the model on which many other programs have been patterned.

Project Hope has capacity for 8 small families or 20 people in bedroom suites. The program is designed for women and their children, with no restrictions on the age of the boys in the family. Since opening, Project Hope has served 500 homeless women and their children.

Points of Entry

Project Hope is a 24-hour, year-round shelter. Families are referred through DPW, community agencies, and self-referral. It has a van that is used to help transport women back to the shelter for the on-site GED program.

Service Delivery

Project Hope's focus is on advocacy, assisting clients in linking to community services, and empowerment. Staff resist setting up a separate service delivery system. Services offered by Project Hope combine off-site referrals and on-site programs.

On-site training provided by Project Hope focuses on housing search, personal and family development, parenting, budgeting, and empowerment. Staff help clients explore their circumstances and how they got into their homeless situation. Individual counseling is available as needed. A local banker has developed a training program for new residents on how to become credit-worthy; other training topics have included AIDS and political awareness. Staff assist clients in making links for health care, benefits, education, social services, and housing. The Boston Health Care for the Homeless (HCH) team conducts adult health assessments and pediatric evaluations on-site every 2 weeks.

Project Hope recently arranged to have a GED program on-site for shelter residents and formerly homeless families that have been through their program. This is coupled with child care for the children and transportation.

Project Hope has developed strong community relationships and has established linkages with colleges, banks, and other community groups for various training programs. Project Hope also offers residents a voluntary savings program. As an incentive, savings are matched with 25 percent interest.

Staff encourage families to choose the magnet system for education, which provides stability regardless of where they are permanently housed.

The average length of stay for program participants is 3 to 4 months. Staff report that it has become longer and just 1 year ago it was 10 to 12 weeks. Program participants leave the program when permanent housing is found.

Another program component of Project Hope is the "Family Stability and Development in Cooperative Home Ownership" program. In June 1989, as part of this program, a renovated neighborhood three-decker home was opened to three homeless families. The program includes a tenant selection process and human development and skills training to help tenants learn the process and tasks of home management. A second phase of the project includes plans to build eight units of limited-equity cooperative housing on land directly across from the shelter.

Coordination and Effectiveness of Services

When program participants first enter Project Hope, they develop voluntary case plans with the residence coordinator and social worker. Residents are required to maintain weekly logs showing efforts made to find housing.

When women are ready to leave Project Hope, an exit interview is conducted. During the interview the woman is asked to evaluate her stay at Project Hope and review her future goals, needs and concerns. Additional services are offered and considered optional. Most women have opted into the followup program services. The followup program has evolved over the years. Initially, staff would make home visits to help ensure that the family had successfully connected with schools, local health clinics, food programs, furniture banks, etc. Staff noticed that families would call back when problems arose. In response to these issues, Project Hope initiated a women's support group. The support group includes transportation and child care. Out of this support group, Project Hope identified the need for an on-site GED program and coupled it with human development training. They decided to offer the program on-site because of the lack of transportation and child care for the women.

Effectiveness is defined as stably maintaining permanent housing. Although most clients find permanent housing, a followup program has been instituted for those who want it. This is described in more detail under "Case Planning."

Financial Issues

Project Hope has a $500,000 operating budget. Funding sources include: 46 percent from DPW, FEMA, and McKinney grants; 25 to 30 percent from private fundraising; the remainder from foundation and corporate grants.

Staffing

Project Hope has a total of 13 FTE positions filled by 22 people. These include 5 house managers, an assistant coordinator/housing advocate, a child caregiver, 3 followup staff, a development person, a volunteer coordinator, a part-time secretary, a part-time residence coordinator, a part-time bookkeeper, a part-time maintenance person, and a housing coordinator. They also have a pool of 20 volunteer staff.

Barriers and Issues Identified

Staff report that families continue to experience difficulty with finding day care opportunities. They try to get linked to Head Start and child care subsidies, but both programs have very long waiting lists.

Medford Family Life

Organizational Issues

Medford Family Life is a transitional housing program for women and their children. It opened in August 1989 and is housed in a newly renovated Victorian house in Medford. It is one of three Boston-area shelters run by Shelter Inc. The other two facilities include a family shelter located in Boston and an adult shelter in Cambridge. The concept for the Medford program sprang from the experiences of the other two shelters and the realization that for some homeless families, it is not enough to get housing. Often they were seeing some of the same families coming back into shelter. Medford was established to help families develop the skills necessary to live on their own and meet the range of needs including housing, education/training and life skills.

Medford can accommodate a total of 15 families. Accommodations include individual bedroom suites with private baths and common living and eating areas.

Points of Entry

Referrals for Medford Family Life come from the State Department of Social Services (DSS), DPW and others. Clients come from hotel/motels, other shelters or other marginal living situations.

Potential clients are screened during an off-site interview to determine whether they are appropriate for the program. Clients must show a commitment to working on specified goals and making changes in their life.

Waiting lists are not maintained for the program. When program staff know that a vacancy is coming up, they begin interviewing potential candidates referred from various sources.

Initially five to six women were being interviewed for every slot; that number has been reduced to three, mostly because referral sources know more about the program and refer only the most appropriate clients.

Service Delivery

Medford Family Life offers a combination of on-site services and linkages to community services. Their focus is to teach how to access existing services and helping participants get set up with community services to ensure continuity in services even after leaving the Medford program.

A number of services are offered on-site, most of which are required of the clients. These include weekly parenting workshops, weekly group sessions on varied topics, art therapy for the children, and weekly (or bi-weekly) house meetings to review house-related issues. The family also meets at least once a week with a child development specialist. This program is funded by the Better Homes Foundation and includes assessment and testing and referral for more extensive testing when indicated. The program strives to address the child's special needs, and, through early intervention, bring some experience with success and consistency to their lives. Children with special needs are linked to various programs (e.g. the inpatient program at Children's Hospital or special education programs). Staff may participate in parent/teacher conferences and provide lots of behind-the-scenes intervention to ensure that the child's needs are met.

For parents, Medford emphasizes education rather than training. Participants are not expected to leave the program employed or graduated, but to have laid the groundwork for continued education which will eventually lead to better jobs. They do not emphasize employment because of the disincentives created by lack of affordable child care and ineligibility for entitlement programs.

Medford does not offer on-site child care. They make an effort to help make links to the community to fill this need; however, there is a shortage of subsidized slots and affordable day care. Staff encourage residents to make use of the DSS reimbursement mechanism for cooperative hourly babysitting arrangements; participants can get reimbursed $2.00 an hour.

Medford staff help clients establish links with numerous community resources. Many of the linkages occur through the conferences with the case worker. In addition, links to housing, education and training and child care are made. Staff have a lot of interaction with DSS workers--half of participants already have a DSS case worker.

Program residents are expected to participate in the program for at least 6 months. A typical stay is from 9 to 12 months, the average length of stay in the program is 1 year. Women leave the program when they have found appropriate permanent housing. Clients may stay longer than a year if necessary, some participants have stayed as long as 18 months. Persons can also be evicted from the program for failure to participate, violence, or loss of children. They usually try to work something out with the participants before evicting them.

Coordination and Effectiveness of Services

An individual service plan is developed with each family when they first enter the program. It includes education goals, parenting goals, lists basic rules, agreements, incentives, and consequences. The service plan is reviewed every 6 weeks to monitor progress. Case Planning is considered an integral component of the program and is always done in conjunction with the families.

Staff at Medford Family Life usually take the initiative to call together a case conference with all of the various people and agencies with whom the client may be connected in order to better integrate the services before the participant leaves the program.

Followup is part of the program and services offered include planned and unplanned visits to the home, a weekly program for "graduates," invitations to special events (e.g.holiday parties), and weekly telephone contact. The extent to which women are involved in followup varies depending on individual needs.

Of the 15 women that have participated in the program since it opened, 8 have graduated (7 are still in residence). Two women have been unsuccessful participants and were asked to leave the program.

Financial Issues

Medford Family Life's operational budget totals $1.5 million. Funding sources include 57 percent State and Federal grants/contracts; 13 percent United way; and 30 percent fundraising.

They have Section 8 certificates attached to the program as well as some 707 project based funding. The local housing authority determines what the participant payment should be (typically 30 percent of the adjusted income) and the program collects this amount from the participants.

Staffing

Staff composition includes a full time social worker; full time child development specialist; full time house manager; part time maintenance person; and 9-10 part time house staff.

They also draw on a pool of 50 volunteers to provide services.

Barriers and Issues Identified

Staff indicated that the program did not expect women to be employed or to have finished a degree by the time they completed Medford. Rather, they hoped to show women how to make choices and get them on a plan for these future events.

The staff indicated that affordable day care was the biggest obstacle to self-sufficiency for women in their program.

Women, Inc.

Organizational Issues

Women Inc. is a 17-year old residential program for substance abusing women and their children. It is located in a renovated three-story victorian walk-up in the Roxbury section of Boston. The facility has capacity for 24 women and 10 children. Five beds are reserved for pregnant addicts. The program's goal is to help women move from dependence on drugs, alcohol and public assistance to independent social health and responsibility. Women Inc. served as the program model and pilot for the new network of DPW substance abuse shelters for homeless families.

Women Inc. first started in 1973 with a grant from the National Institute of Drug and Alcohol Abuse (NIDA). At that time women were coming to the program addicted to heroin; now the substance of choice is crack-cocaine. Their target population comes primarily from Roxbury; they are mostly homeless, African-American, have been victims of sexual abuse (80 to 85 percent), come from families with addiction histories, have no benefits, and have been unable to succeed in other programs.

Staff report that the profile of the women that they serve has changed since the program's inception. Now, their client population tends to be younger women (typically in their 20s) with shorter drug experiences, which in some ways is more difficult to address because they have not been through problems related to drug use long enough or often enough to realize the consequences. Also, for younger clients, 12 months seems like a long time to commit to a structured program. While a history of intergenerational drug abuse has been a common phenomenon among their client population, staff report that collateral addiction (i.e., among brother, sisters, aunts) is also becoming more common. This leaves few family members to whom women can turn for support in their efforts to overcome their addiction.

Points of Entry

About half of the program participants are prison or court system referrals; 30 percent institutional (e.g. hospital) referrals; 10 percent are DSS referrals; and 10 percent are self referrals. Potential participants are screened before entering the program; they must have gone through a detoxification program, show a commitment to change, and be able and willing to work within a highly structured program. The program is not equipped to take women who are mentally ill, nor do they take children older than 12 years. They feel that there are too many issues pertaining to stigma and peer relationships for children of this age.

Service Delivery

The program that Women Inc. offers is three-phased and designed to achieve gradual re-entry to the community. The first phase lasts 3-5 months and focuses on stabilizing the client. This phase is very structured; the client's mobility outside of the program is limited as are television, telephone calls, entertainment and other activities. The focus is on what it is like to be straight. Children are not included in the program during this phase. Often they are already in foster care; if not, program staff assist the women in finding temporary placements with family or friends. Program staff have developed an arrangement with DSS which helps to keep the children from going into long-term foster care.

During this first phase, a "big sister" assignment is made. "Big sisters" are women who are in the second and third phases of the program. At the end of the first phase, staff begin to help clients sort out connections with AFDC, Medicaid, probation or parole officers, and DSS workers. They begin steps toward reunification with children who are with family and friends or in foster care.

Counseling takes place one-on-one and in group sessions. House meetings are held every morning. Group therapy sessions are held two to three times per week and incorporate the 12-step treatment program model and confrontative therapy.

During the second phase, women must begin advocating for themselves and decision-making becomes more of a joint effort. They are given more privileges and more mobility outside of the program, but are still accompanied by others. The focus is on exploring circumstances that led them to addiction and feelings related to relationships with family and friends.

The third phase of the program is focused on preparing for leaving the program. During this phase the housing search is initiated as well as linkages to educational/vocational training or employment. Staff are careful about the location of permanent housing to avoid putting women back into the same drug ridden environments from which they came.

Throughout the program, all women attend seminars on addiction and parenting. Pregnant addicts attend specialized classes on child birth and infant care. The entire three phase program typically takes about 1 year to complete.

Services specifically oriented to the children include therapy sessions provided through the local health center and followup groups for the older children which focus on such issues as drugs, addicted parents, conflict resolution, and locus of responsibility. Women Inc. also operates a State licensed child care center on-site. It serves the surrounding community and has capacity for 33 children. They charge a sliding scale fee and some of the slots are subsidized through the DSS voucher system for women attending vocational programs. Usually only three or four of the children in the day care program are from the residence.

Women Inc. also has an AIDS services department which is a separate program for residential outpatient and program graduates which offers HIV education and outreach as well as antibody testing. Another component of this program is a demonstration project funded by the Centers for Disease Control (CDC) to conduct outreach to women in the sex industry.

Women are asked to leave the program if they are physically abusive, continue to use drugs, or are continually unable to follow house rules.

Coordination and Effectiveness of Services

The program takes an active role in case planning for program participants. An extensive intake process is completed and includes a physical and history of drug use, criminal involvement and psychosocial history. The program services are highly structured and progress through the program is closely monitored. After-care/followup services are provided for 1 year and include re-entry group sessions twice a week and urine screening and individual counseling once a week. Some women receive after care from other sources, and Women Inc. assists in making these referrals.

Many women go into transitional programs after leaving Women, Inc. and many move into shared living arrangements with other program graduates which helps them to maintain their established support systems. Staff report that suitable housing is difficult to locate, and there are few subsidized slots available. The program reports a 60 percent retention rate and an 80 percent success rate measured by the number of women who stay drug-free for at least 2 years after completing the program.

The program has served 1,400 women and 300 children in their drug treatment and other programs since opening in 1973.

Financial Issues

The program revenues total around $529,000. Funding sources include city and State contracts (71 percent), fundraising (27 percent), and client fees (2 percent). DPW provides funding for the pilot program to develop substance abuse shelters.

The cost of running the program is estimated at $70.00 to $75.00 per day for the residential program and $100 to $110 per day for the pregnant addicts program.

Staffing

The core program staffing includes a program director, 2 specialized coordinators, 4 day-time counseling staff, 2 night-time and weekend counseling staff, and a housing specialist. Additional staff are associated with the child day care center and AIDS program.

Barriers and Issues Identified

Safe, affordable housing is not available; women often return to the unsuitable environments from which they came. Affordable day care is another obstacle to long-term success of the participants.

Staff also indicated that their clients experience difficulty in accessing welfare benefits, the major obstacle cited was the paperwork required and the often lengthy waits to receive birth certificates and other required documentation.

Kidstart--Boston Children's Hospital

Organizational Issues

Kidstart was initiated 2 years ago with funding from the Better Homes Foundation. In its second year it was funded by IBM with Better Homes administering the funding. The third year funding is still pending. Since the site visit, the program has undergone several significant changes which are briefly summarized at the end of this description.

The initial purpose of Kidstart was to provide services to preschool children in homeless situations to help them develop the necessary literacy, language, and social competency skills to be successful in school. Kidstart targeted homeless families residing in hotels and motels. Because they were placed outside of the shelter system, these families lacked services, yet were often the families with the most problems.

Subsequently, staff reported a change in target population over the 3 years of the project. Initially they were seeing about 20 families in hotels/motels. During the second year of the project they were seeing as many as 100 families and 200 or more children; now they see between 10 and 20 families. They attribute the decrease largely to 1) the DPW assessment process which has changed the criteria for qualifying for emergency shelter and 2) the "word on the street" that there are no Section 8 or 707 certificates available.

Since the number of families in hotels/motels has decreased, staff are exploring other ways to identify clients in need of services. They have started outreach efforts to the shelters in the greater Boston area.

Kidstart has seen about 100 families in the last year and continues to have varying levels of contact with these families

Points of Entry

Kidstart staff visited the hotels/motels on a weekly basis. The team included a child psychologist, bilingual pediatric nurse practitioner, and a pediatrician. A family health nurse on loan from Boston City Hospital's Health Care for the Homeless (HCH) program also goes on visits.

Service Delivery

An initial developmental assessment and screening is conducted on-site at the hotel in the child's environment; referral for followup testing is made when indicated. Staff make linkages with local schools, Head Start, and day care centers with the parent's permission, to help ensure that the children's needs are met.

The pediatrician provides medical screening, makes referrals and linkages to subspecialties, and emphasizes the need for parents to maintain their relationship with their primary care physician.

Kidstart does not have any formal relationship with DPW, although they are planning to initiate meetings with DPW to explore access issues.

Linkages with schools included weekly visits to the schools near the hotels where families were housed and meetings with teachers on a case-by-case basis.

Coordination and Effectiveness of Services

Case planning is minimal because of the short duration of contact with the clients. Kidstart staff attempt to follow clients even after housing is found, but find that families are capriciously moved and that it is difficult to track clients after they leave the motel. Often they are relocated to shelters, but staff have found that shelters are concerned about client confidentiality issues and have not always been able to give Kidstart staff access to clients.

The need to provide followup services depends on the shelter. The quality of services in shelters varies widely, and staff feel that they usually need to continue to follow clients to ensure that developmental/educational service needs are followed-up.

Financial Issues

Kidstart's budget totals $65,000. The application for funding for next year is pending.

Staffing

Project staffing includes a .4 FTE educational psychologist, .2 FTE bilingual nurse practitioner, and a .1 FTE pediatrician.

Barriers and Issues Identified

Staff identified a need for better systemwide case management and followup and also indicated that the long waiting lists for Head Start programs were a barrier to needed services. The special education evaluation and placement process is also considered long and unwieldy.

Staff also felt that some necessary gatekeeping occurs in shelters making it difficult to gain timely access to families in need of Kidstart services. The frequent moves within the homeless service system that are common for some families was also cited as a program barrier.

Since the site visit in December 1990, the program has undergone several substantial changes. These are summarized below.

- Point of entry is in shelter after receiving a call from a shelter staffperson who (through word of mouth) requests services for a client.

- Service delivery includes developmental screening only, the medical component has been discontinued.
- Kidstart can recommend further evaluation for children, preschool special education, support groups for parents or multidisciplinary evaluation at Children's Hospital.

Cambridge Multi-Service Center

Organizational Issues

The concept for the Multi-Service Center was developed four to five years ago. The city had a funded emergency services position, which they found was expanding into a crisis center. They decided to bring together everyone working with homeless into one place so the approach could become more coordinated and less crisis-oriented. The original concept has evolved over the years and has been successful to varying degrees. The State Department of Mental Health (DMH) has located a staff person there; however, DPW and DSS have not agreed to locate offices in the center. The Multi-Service Center is under the direction of the Planning and Development Division of the City Department of Human Services (DHS).

The City of Cambridge has always had a progressive city government which has been aggressive in negotiating contracts with the State. They have also adopted an aggressive fundraising stance in relation to the Multi-Service Center. Staff report that the advantages of city affiliation include clout and access to the necessary administrative mechanisms; however, they are accompanied by the disadvantages of having to go through the typical bureaucratic channels and city regulations.

Points of Entry

The Multi-Service Center serves Cambridge residents. Many families are referred through the welfare department; many others are not linked to welfare and are self-referrals. The Center is open five days per week.

Service Delivery

About half of the services available at the Multi-Service Center are city programs funded through Community Development Block Grant (CDBG) funds, city tax dollars, contracts with the State, and privately raised funds. The remainder of the programs are affiliated with non-profit organizations. Services include housing search, mental health, a furniture bank, Teens in Transition, and social case workers. However, most of the services are linked in some way to finding and keeping affordable housing. Also located in the building is the Community Learning Center, which provides English as a Second Language classes, adult basic education, and GED classes.

Links to services in the community have been enhanced through the co-location of services and referral sources. Other services within the community include: day care, food pantry, toy drives and clothing drives and medical referrals.

There is no limit to the duration of services; staff continue with clients until they find permanent housing. They also followup to ensure that the relationship is going well.

Coordination and Effectiveness of Services

Information and referral flows smoothly. Cambridge has always had an active service provider network and the Multi-Service Center has enhanced the ability of providers to coordinate services.

Case planning for housing search participants includes case conferences when problems occur; for example, towards the end of the 90 day stay in shelter, or when clients are in danger of being evicted from the shelters. They typically include the housing specialist, DSS, DMH and shelter staff. City caseworker staff continue to follow clients for up to a year after they have been placed in permanent housing.

Effectiveness is defined as placement in permanent housing; however, no outcome data were available beyond simple process measures.

Financial Issues

Not available.

Staffing

Multi-Service Center staffing from the City of Cambridge includes the center director, three housing search staff, two YMCA transitional housing program staff, an emergency services worker, an elderly and disabled caseworker, and a receptionist. Other staff include a social worker from Shelter, Inc., a DMH caseworker, 3 part-time staff from Teens in Transition, staff support for the St. Paul's Furniture Bank, and staff for Project LIFT--a McKinney funded program to provide adult education for the homeless through the Community Learning Center.

Barriers and Issues Identified

None were identified other than affordable housing and the difficulty of accessing this when there are 250 local housing agencies to deal with across the State.

Salvation Army Day Care Center

Organizational Issues

The Salvation Army in Cambridge operates an adult shelter and a day care program for families residing in local shelters. The day care program was started more than 4 years ago when the city DHS approached Salvation Army with the idea for a half-day, two day per week program to allow women in shelters to conduct their housing search. The city of Cambridge provided the start-up funding for the program.

It has since expanded to a 5-day program, open from 9:00 a.m. until 1:00 p.m. with capacity for 25 children. It accepts children ranging in age from 3 months to 5 years.

The program has an exemption clearance from the State Office for Children but is currently going through the licensing process for liability protection.

Points of Entry

The program is available free of charge to all families in Cambridge-area shelters. Access is through the shelter system or DSS. The program has been able to meet the demands for services and have not had to maintain a waiting list. In a few instances the need has exceeded the demand, and in order to be able to serve everyone, the program restricted participation of infants to 3 days; however this was a not long-term situation.

Service Delivery

Program services include developmentally appropriate activities for the children including weekly visits to the gym and library, play therapy, a weekly voluntary support group for mothers, and a monthly luncheon for mothers which may include fellowship or special presenters such as staff of DPW or DSS.

The Salvation Army Day Care Center has established links to early intervention programs and other related community services.

The program operates on a drop-in basis. Children can stay in the program after the family is permanently housed until another day care situation is located.

Coordination and Effectiveness of Services

No case management is done by the center; effectiveness is tracked only in process terms.

Financial Issues

The total budget for the program is about $110,000. The program's funding comes almost entirely from private trusts and grants. The State DSS vouchers for cooperative babysitting cover only 1 to 5 percent of operating costs. This has been decreasing, and they have experienced problems getting vouchers processed.

Staffing

Center staff include a full-time director, a full-time lead teacher, 1 full-time and 1 part-time teacher, and 3 teacher's aides.

Barriers and Issues Identified

None raised.

Network for Children

Organizational Issues

The Network for Children grew out of the Malden-area Office for Children, a State-supported children's advocacy organization that worked with individuals and also developed grass roots and class advocacy.

The staff of the Malden-area Office for Children were very advocacy oriented and felt that more could be done as a non-profit organization. The Network for Children was the result; it became a separate non-profit organization about 18 months ago.

The Network's services consisted initially of support groups for homeless mothers. They soon realized that there were 65 to 70 homeless families from Boston being placed in local hotels and motels; the Network began to play a "welcome wagon" function for these families, introducing them to the area, getting their children enrolled in local schools, locating services for the mothers, and providing advocacy.

Points of Entry

Network staff do outreach to hotels and motels in the Malden area. Services are available free of charge.

Service Delivery

Program services initially included a "survival kit" resource book for newly arrived homeless mothers. That has since become a minor part of the services which now focus more on intensive support for mothers. These include Monday support sessions and Friday substance use groups. Individual counseling is also provided during the week. Breakfast and lunch are provided on groups days; a free children's program is also provided during the group sessions. Besides the counseling services, Network staff provide advocacy and try to link families to services in the area. Screening of children is done in conjunction with Kidstart, a mobile health care service of Boston Children's Hospital; then the Network tries to link children with developmental delays to local services.

Services are available to families for as long as they wish to participate. Generally, the families are involved during their motel or hotel stay; these can be as long as 7 to 8 months, although they may move to several locations during that time.

Some families continue in the program even after being permanently housed; indeed, one program goal is to expand the stabilization component to reach women who have left the program for permanent housing in Boston.

Coordination and Effectiveness of Services

Case planning is done informally; the staff puts considerable effort into linking families to services. Effectiveness is tracked only in terms of process measures.

Financial Issues

The program's funding comes almost entirely from private donations and grants. Space is provided free.

Staffing

Center staff includes a director and a corps of volunteers who work with the families and operate the children's program.

Barriers and Issues Identified

The Department of Public Welfare is placing fewer families in hotels and motels; thus the main population addressed by the Network is dwindling.

Stabilization services are needed for women once they are stably housed. Substance abuse problems tend to become worse once women are housed because they have few informal supports and have excessive free time.

With more funds, the program would expand to include a full-day program for women, provide groups additional days of the week, expand the substance use component of the program to include additional days and additional sites, and provide drop-in day care.

Staff believe that the Network has difficulty attracting funding because it provides services in a non-traditional way; it focuses on empowerment and on developing the capacity of the homeless participants.

Chapter IV

Site Visit Report

Minneapolis, Minnesota

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Chapter IV. Site Visit Report--Minneapolis

I. Introduction

The site visit team selected Minneapolis as a site visit to get broad geographic representation in the study sites and because the mainstream human services infrastructure in Minneapolis--and the State of Minnesota--was known to be extensive and well-funded. The team also understood that the commitment of the public and of the corporate and non-profit community to this problem was high. The site visit team was interested in exploring how homeless services operated in an environment in which mainstream services were good. Would efforts be directed at linking people to mainstream services or would a dedicated system develop anyway?

II. Overview of Site Visit

The Macro study team conducted interviews in Minneapolis on November 12 through 14, 1990, to explore how the city's service delivery system is meeting the needs of homeless families with children. During the site visit, the study team interviewed representatives of State and local government agencies, advocacy groups, and service providers.

Officials from the following State, county, and city offices were interviewed:

- Hennepin County Social Services
- State Department of Education
- City of Minneapolis School District
- City of Minneapolis Health Department
- Hennepin County STRIDE program, the State's response to Federal welfare reform (JOBS) requirements

Representatives of advocacy and interest groups included:

- United Way of Greater Minneapolis
- Minneapolis-St. Paul Family Housing Fund

In addition, the site visit team interviewed staff and toured facilities of the following service providers:

- 410 Family Shelter, the largest family shelter in Minneapolis
- The Learning Center, an on-site children's program for residents of the 410 Shelter
- Passage Community, a congregate-model transitional housing program

- Elim Transitional Housing, Inc., a nationally-known scattered-site transitional housing and services-enriched housing program
- Emerson School's Transitional Classroom Program and Connections Program, special programs which accommodate homeless children until their families are settled in permanent housing
- Hennepin County Homeless Assistance Project, a McKinney-funded Health Care for the Homeless Project

In addition, after the site visit, team members interviewed staff of the following two programs by telephone:

- Project Secure, a transitional Head Start program for infants, toddlers, and preschoolers in selected family shelters.
- The Hennepin/McKinney Training and Employment Program for Homeless Families, a McKinney-funded employment program that is operated under the auspices of Catholic Charities.

The purpose of these discussions and program surveys was fourfold: (1) to gain a general understanding of the size and scope of the problem of family homelessness in Minneapolis, (2) to outline the service delivery system in the city as it serves these families, (3) to describe innovative service programs, and (4) to identify issues and barriers preventing homeless families in Minneapolis from gaining access to the services they need.

Exhibit 1 describes all of the interview participants for the site visit. Exhibit 2 presents a flow diagram depicting the interrelationships of the main components of the service system for homeless families in Minneapolis. Profiles of the programs visited are attached in the appendix. These represent selected examples of some of the programs that compose the service delivery system in Minneapolis.

III. Contextual Issues

As in cities and counties across the Nation, in Minneapolis there is no single factor responsible for family homelessness. Rather, many factors combine to increase the risk that an individual or family will become homeless.

The approaches to addressing the issues presented by family homelessness are heavily influenced by the social, political, and economic environment. The next section describes the characteristics of the homeless family population, some of the factors related to causes of family homelessness, when and how a response to the problems took shape, and the political and social climate in Minneapolis.

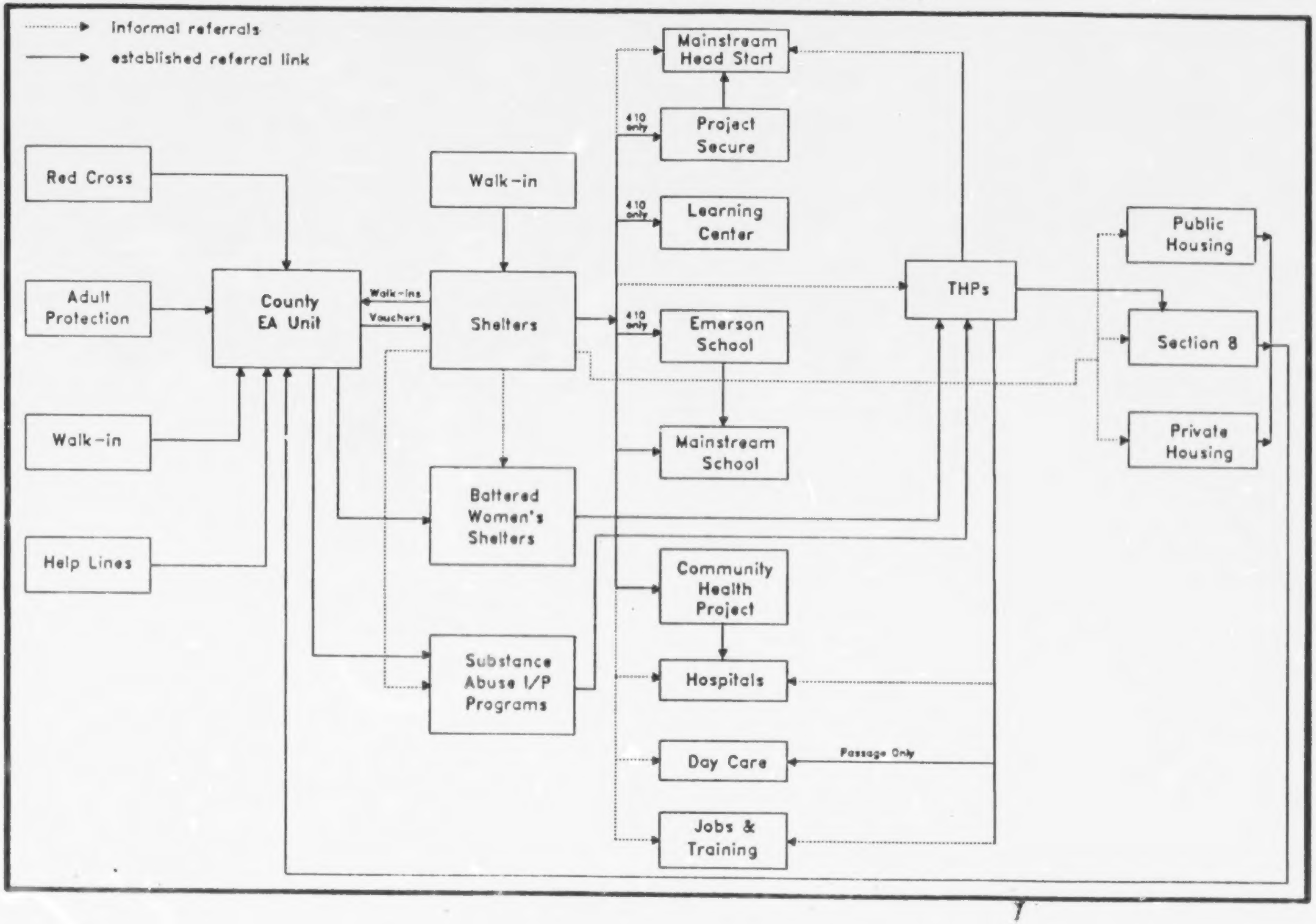
EXHIBIT 1

DESCRIPTION OF SITE VISIT PARTICIPANTS: MINNEAPOLIS

Program Name	Organization Type	Services	Toured Facility
United Way of Greater Minneapolis	Funding and Coordination	Funding of prevention and coordination projects	
The Learning Center	Children's Program	Half- and full-day educational programs, after school programs for children in shelters	X
410 Family Shelter	Shelter	Shelter and services for homeless families with children	X
Minneapolis-St. Paul Family Housing Fund	Funding and Coordination	Funding of "More Than Shelter," an affordable housing program	
Passage Community	Transitional Housing Program	Congregate transitional housing and services for homeless women with children	X
Elim Transitional Housing, Inc.	Transitional Housing Program	Scattered-site and congregate transitional housing for homeless families with children, services-enriched housing	X
Minneapolis Public Schools, Emerson School Transitional Programs	Alternative Educational Programs	Half-day transitional classroom for homeless elementary students, alternative programs for homeless high school students	X
Hennepin County STRIDE Program	Employment Program	Oversight of STRIDE program, State version of Federal JOBS program	
Hennepin County Homeless Assistance Project	Health Program	Mobile and clinic primary care services, referrals to specialty care	X
Hennepin County Social Services	Economic Assistance and Support Services	Shelter voucher distribution, reimbursement of shelters	
Project Secure	Head Start	Dedicated Head Start program for sheltered homeless children ages 6 weeks to 5 years	
Hennepin/McKinney Training and Employment Program for Homeless Families	Employment Program	Employment and training program for homeless families with children	

EXHIBIT 2

FLOW OF CLIENTS THROUGH THE SERVICE SYSTEM: MINNEAPOLIS


informal referrals
established referral link
Mainstream Head Start
Project Secure
410 only
Learning Center
410 only
Red Cross
Walk-in
Public Housing
Adult Protection
County EA Unit
Walk-ins
Vouchers
Shelters
410 only
Emerson School
THPs
Section 8
Walk-in
Mainstream School
Private Housing
Battered Women's Shelters
Help Lines
Community Health Project
Substance Abuse I/P Programs
Hospitals
Day Care
Passage Only
Jobs & Training

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A. Size and Characteristics of the Population

The Wilder Research Center, part of the Amherst H. Wilder Foundation, is the major source of information on the size and characteristics of Minneapolis' homeless population. Its most recent data are derived from a shelter survey conducted on a single night in February 1990. It is widely believed that the homeless family population is growing, both in absolute numbers and as a percentage of the total homeless population. County data from FY 1989 indicate that there were approximately 1,200 unduplicated families in the family homeless service system. Unlike many cities, in Minneapolis the number of homeless families is highest in August and September--up to 250 on any one night--and lowest in winter months--100 or less on any given night. Families are believed to constitute approximately one-half of the total homeless population.

As in most cities, the typical profile of a homeless family is a mother with two to three children. The homeless population is disproportionately nonwhite; the Wilder Foundation data indicate that almost two-thirds (63.6 percent) are African-American. Minneapolis also encompasses several small ethnic groups including Pacific Islanders, Southeast Asians, and one of the largest urban concentrations of Native Americans. While some members of these ethnic groups are homeless, the site visit team did not find any homeless programs directed specifically at them, although there are several transitional housing programs in the Twin Cities especially for Hispanic or Native American women in crisis, including homeless women.

The providers interviewed indicated that few of their recipients were working, and of those, few had full-time employment; only 7.6 percent of family respondents to the Wilder survey had derived any income from employment in the last month.

In-migrants are a far larger component of the homeless family population in Minneapolis than in the other cities visited. Shelter providers estimated that about 50 percent of their families are not residents of Hennepin County--the county in which Minneapolis is located. The Wilder Foundation survey found that 53 percent of homeless women with children had lived in Minneapolis less than 2 years. AFDC workers estimated that about two-thirds of new AFDC cases were in-migrants. While some of these in-migrants come from the surrounding nonurban counties, many come from surrounding States. Chicago, Illinois, and Gary, Indiana, are two localities frequently cited. The issue of in-migration has exacerbated controversy about homeless people. Some feel that Minnesota's liberal welfare benefits are attracting the in-migration, whereas others believe that homeless in-migrants are coming for the same reasons as middle and higher income in-migrants--low crime, good schools, and other quality of life issues. Indeed, these experts point out, the pattern of origin for homeless in-migrants closely resembles that of middle and upper income in-migrants. However, because homeless in-migrants tend to be African-American, they are more visible in the predominantly white local population.

B. Factors Related to Family Homelessness

Economic or Structural Factors. The Twin Cities Metropolitan Area was strong economically throughout the 1980s. The economy is reasonably diversified; routinely the unemployment rate was lower than the national average. The core cities of Minneapolis and St. Paul are not as strong. Just recently, the Mayor's Office announced that the tax base in the downtown area--where retail and financial activities are concentrated--was expected to decline significantly.

Affordable housing is cited by advocates as the major cause of homelessness for families. Staff in the Economic Assistance Department indicate that the affordability guidelines given local families--these are based on average local rents--include rents of 70 percent to 80 percent of the typical AFDC benefit of $532 per month for a family of three. A May 1990 survey by the Minnesota Coalition for the Homeless found that 89 percent of homeless women with children indicated that affordable housing was their main need.

The availability of affordable housing has been further reduced by aggressive downtown development. Construction of a new sports arena and expansion of the convention center both displaced low-income units. In the last 15 years, about 2,500 units of single-room occupancy and low-income housing have been abandoned or converted to other uses. Changes in the tax law on passive income have caused absentee landlords to leave property unrenovated. The resulting large number of boarded-up buildings on the outskirts of downtown further infuriates those who believe that the city is not seriously addressing the issue of affordable housing.

The Twin Cities has a housing vacancy rate of about 9 to 11 percent. Besides affordability issues, however, access for homeless families is limited because the vacant units are the wrong size, or in the wrong place. There is a glut of one bedroom units, for example, whereas the typical homeless family needs a larger unit. The Wilder survey found that 52 percent of homeless families needed a two-bedroom unit and 33 percent needed three or more bedrooms.

There are many models of affordable housing in the Twin Cities and many very strong developers. These models have been directed at low-income families in general rather than at homeless families in particular and the site visit team did not have the sense that the two sets of programs were well integrated.

Few homeless women with children are working--only 7.6 percent of Wilder respondents had derived income from employment in the last month. Affordable childcare is the most frequently cited obstacle to self-sufficiency. Wilder data indicate that 72.7 percent of homeless women with children cited this as their major barrier to employment.

Individual Factors. Providers did not cite the percentage of homeless families for whom substance use or mental illness are contributing factors. Indeed, the Minneapolis provider community has a strong ideological bias against blaming individual dysfunction for homelessness, and this may have influenced the answers. County staff estimated that only about 10 percent of the homeless family population had serious substance abuse issues as a contributing factor in their homelessness. Wilder Foundation data indicate that only 7.6 percent of homeless women with children have a substance abuse problem; 15.2 percent of women have left employment because of a mental health problem.

Domestic violence is felt to be a major contributor to family homeless. There are several battered women's shelters, but these are only peripherally connected to the homeless services system. But shelter providers, and especially THP providers, indicated that many of their participants had been in abusive relationships and that abuse had played a role in their homelessness. Wilder Foundation data indicate that 37.9 percent of homeless women with children had experienced physical abuse as children and 44 percent left their last housing because of abusive situations. This is somewhat higher than the estimates of county staff--that 25 percent of women had domestic violence as the precipitating cause of their homelessness. County staff estimate that for 25 percent of women heading homeless families, domestic violence is the precipitating cause of their homelessness; for almost three-quarters, it is one of the contributing factors. Providers are becoming aware that the emergency shelter system is serving as overflow for an overburdened battered women's service system.

The State's commitment to deinstitutionalization of State hospital populations is believed to have contributed to homelessness. Studies indicate that half of the homeless who have substance abuse or mental illness problems have been discharged from an institution without a community placement; however, this tends to affect the single homeless population more than the family homeless population.

Homelessness is episodic for families in the Minneapolis system. Wilder Foundation data indicate that 85 percent of families have been homeless less than one month. According to county data, shelter average length of stay is approximately 11 days, although almost one-fifth of residents must renew their voucher beyond the original 30-day period.

C. Development of a Response to the Problem of Homeless Families

See the discussion below on political and social climate.

D. Political and Social Climate

Several aspects of the political and social climate in Minneapolis have shaped the development of a response to the problem of homeless families, including the following: political jurisdictions within the area, the historically strong commitment to social services, a strong tradition of corporate philanthropy, the service ideology, and public attitudes.

Political Jurisdictions. The Metropolitan Area encompasses seven counties and two core cities--Minneapolis and St. Paul. Bloomington, which in the past was typically considered a suburb of Minneapolis, has more recently emerged as a third core city encompassing the areas of strip development and corporate development along the I-494 beltway and near the Twin Cities International Airport. Despite the multiple jurisdictions in the Metropolitan

Area, there is a tradition of regional cooperation. The Metropolitan Council is a regional government with fairly extensive control over development of the physical infrastructure. In social services, it has very little direct authority, but provides research and development, and information and referral services, and acts as a forum for discussion of region-wide issues in health and human services.

In selecting the Twin Cities as a site, the team was advised to focus on only one of the core cities rather than to treat the Metropolitan Area as a system. Despite the strong regional structure, the homeless service system tends to be relatively self-contained, and somewhat different, in each city.

The City of Minneapolis is wholly contained within Hennepin County. In Minnesota, social services are delivered primarily at the county level through State formula grants matched with county dollars, although some recent changes have increased the State funding role.

The roles to be played by the various governmental and voluntary actors in addressing homeless services has been the focus of recent debate. St. Paul, in the opinion of most experts the site visit team interviewed, has done a better job of coordinating roles. In Minneapolis, the outcome of the recent discussions demarcated the roles as follows: the city will continue to fund shelters (meaning capital development and renovation of buildings), the county funds social services (including shelter operational costs), and United Way funds prevention and linkages. State government is involved in local services because State formula grants to counties fund programs such as Job Training Partnership Act (JTPA), Aid to Families with Dependent Children (AFDC), and Medical Assistance (MA). the site visit team also identified some special State appropriations from the Housing Finance Agency and Department of Jobs and Training for transitional housing.

Strong Commitment to Social Services. Minnesota historically has had a strong commitment to social services. The State has a well-funded and broad human services infrastructure. AFDC benefit levels are good relative to other States, although they have not been increased since 1983 and are not high enough to make housing affordable at market rents. The service system includes publicly-funded social services and a very large private/non-profit system--Catholic Charities and Lutheran Social Services are the two largest. These services are available to low-income people whether or not they are homeless. As several informants indicated, although all programs could use more money, sheer survival of programs is not really an issue.

Currently, there is a debate about the role of service providers, reflecting some fundamental differences in thinking about how people get "well." To a greater degree than in the other cities visited, advocates were committed to a philosophy of empowerment of clients, resisted the use of the term--and even the practice of--case management. In its extreme form, some advocates see any attempt to exert control over clients or to tie benefits to performance as "oppression" of "victims." More commonly, advocates resist the notion that people must "connect up" to services, which they see as rooted in a social engineering idea that people can be "plugged in" and transformed.

Corporate Philanthropy. Minnesota has a very strong tradition of corporate philanthropy. The area contains a disproportionate number of headquarters of Fortune 500 corporations; many of the home-grown ones such as 3M, Pillsbury, Dayton-Hudson, and General Mills have spun off large foundations which make major grants in social services. Corporate civic responsibility is a deeply held value in Minneapolis. Most of the large corporations are active in the community; many participate in the "Five Percent Club," which refers to the post-tax proportion of income which is distributed as charitable contributions. Indeed, a recent concern is that the takeover of local corporations by multinational firms would lead to a reduction in their sense of commitment to local charities and causes. Thus far, the fear seems unfounded.

Service Ideology. The ideology of service for homeless families is dominated by an aversion to emergency shelters as a solution. This is ironic since the Minneapolis system is dominated, to a far greater extent than the other cities visited, by a single very large shelter, the 410 Family Shelter. Perhaps as a reaction to that reality, the provider and advocacy community has worked on developing alternative models. For example, the city has allocated its share of Emergency Shelter Grant (ESG) funds to the More Than Shelter program--a public-private venture to develop a housing continuum.

The Minneapolis system and especially the transitional housing (THP) component tries to intervene before people become too dysfunctional. For example, the THPs tended to develop networks in the surrounding community so that at-risk and homeless people can be identified and served before they need to obtain emergency shelter. However, the downside of this admirable goal is that neither of the THP programs the site visit team visited drew their clients from the emergency shelter population or had established referral links with the shelter community. The team was told that other THPs have better links to emergency shelters.

Non-profit affordable housing developers--who deal with a general low-income population--have increasingly seen the need for social services in order to stabilize some of their residents. An initiative by the United Way was intended to strengthen the link between housing operators and existing social service providers as an alternative to developing new settings or turning housing operators into new social service agencies. This model is consistent with the goal of many homeless advocates who are looking for alternatives to congregate transitional housing.

Public Attitudes. With the exception of a period of labor unrest in the 1930s, Minneapolitans have tended to deal with social problems in a polite and "civil" way. However, several informants have commented on the more militant stance taken recently by homeless people--squatters organizations are taking over abandoned buildings, for example. Up and Out of Poverty is one organization in a more militant mode.

As in most cities, there is talk of a "homeless backlash" in Minneapolis. Some informants feel that the public commitment is waning. Others believe that the public commitment has not changed; it always has been crisis-oriented and rarely moved beyond the commitment that no one freeze to death in winter. The in-migration issue has weakened public commitment further, to the degree that it fosters a perception that Minneapolis has become a magnet for welfare cases from other States.

IV. System Coordination Efforts

Minneapolis has a number of coordination efforts that take place at the government agency and service provider levels that contribute to coordinated service delivery at the individual family level. A brief description of these efforts is presented below.

A. Coordination Efforts at the Agency Level

The site visit team found no collaborative efforts at the public agency level. The central role of the county Economic Assistance Department obviates the need for coordination that is more necessary in some of the other cities the site visit team visited.

Within local government, no central contact or office in either the city or county integrates homeless services. This is in marked contrast to the situation in other site visit cities and reflects, in part, the philosophy that there is a human service infrastructure in place that is open to all low-income people, including homeless families.

One collaborative link that would be helpful is a stronger relationship between county Social Services and the Housing Authority. There appears to be no link currently. And, as in most of the cities the site visit team visited, the links between Economic Assistance and Social Services are not as well-established as would be desirable.

Although there are no agency-level collaborative efforts, public agencies are intimately involved in many of the provider-level collaborations and public-private joint ventures described below.

B. Coordination Efforts at the Provider Level

Philosophy. Overwhelmingly, informants in Minneapolis expressed a philosophy of client empowerment and linkage to mainstream services rather than creating a duplicate or dedicated system. While it is true that Minneapolis has a very well developed and well-funded human services infrastructure, it is not true that, as one informant indicated, "homelessness does not entitle you to anything that you would not otherwise be entitled to." In fact, the site visit team found several services that targeted, or were even dedicated exclusively to, homeless people. Project Secure is one of the very few Head Start programs in the Nation dedicated to homeless children and the needs of homeless families. The special programs at Emerson School and Health Care for the Homeless (HCFH) are two typical programs that provide special services to homeless people by virtue of their homeless status, even though the ultimate goal is to link homeless families to the mainstream system.

Minneapolis is almost unique among the cities visited in that there is a well-developed human services system to which homeless people can be linked. Consequently, even though follow-along services are not well developed, if the links are made while the family is homeless, there is a mainstream system that can continue to serve the family once they enter permanent housing.

A few factors specific to Minneapolis are responsible for the system as it currently exists. First, the large number of in-migrants requires some period of dedicated services merely because new arrivals are not immediately eligible for entitlements; for example, processing AFDC applications may take several months because of the documentation requirements. Second, the relatively small size of the homeless family population makes the problem seem manageable. For example, the possibility of serving all homeless children in a Head Start program exists, not the case in some other cities visited. Third, the size of the 410 Family Shelter creates a captive audience for all types of services and is attractive for mainstream providers who are trying to establish linkages. The downside of the size of the 410 Shelter is that families do not get the personal attention they do in smaller shelters, and aggressive case management is not available unless the family advocates for itself or fortuitously enrolls in a service program with a good case management component.

Coordination Vehicles. The Minnesota Coalition for the Homeless is the main advocacy organization and involves most of the major players. There are other, more informal coalitions as well. For example, major funding groups have an informal coalition as do some of the housing organizations.

Some informants indicated that within the Minneapolis system, there substantial vertical integration but not much horizontal integration among providers. That is, social services people interact, and housing people interact, but not many bridges have been built between them. The incentive for agencies to collaborate is not high, according to these informants.

Just prior to the site visit, a broad-based task force on homeless issues had issued its report on the single homeless system and was about to begin a similar effort on family homelessness. Among other things, the report suggested roles for each of the major players--the city, county, voluntary funders such as United Way, and the providers. These recommendations are expected to move the discussion forward and to lead to some explicit collaborative agreements among these parties, as has already occurred in St. Paul.

Although the roles of the various levels of government and providers are somewhat fuzzy, considerable collaboration appears to exist among public and private providers. Again, some of this is facilitated by the size of the 410 Shelter, which ensures that the bulk of the family homeless population can be reached in one location, and by the philosophy of the 410 Shelter which defines its role as provision of room and board only. The shelter is licensed as a hotel/motel and the parent organization prefers to use collaborative agreements to provide services on site rather than to undertake its own service provision. As a result, there are formal and informal links to the shelter by most major parts of the system. These include the following:

- The most visible is the link to the Learning Center, a separate nonprofit organization funded through the Community Action Agency. The Center is housed on the main floor of the 410 Shelter and provides services almost exclusively to its residents.

- The link between the shelter, the Learning Center, and the school district to provide the transitional programs at Emerson School is another very visible and smoothly operating link. This flows over into a more established relationship between the education social worker and the shelter, with the social worker visiting families almost daily at the shelter.

- The county Economic Assistance staff does information and referral several times per week.

- The county-funded HCFH project staffs a clinic at the 410 Shelter 4 days per week.

While many, if not most, of these services are available to residents of other shelters, the existence of a large aggregation of homeless families in one location and under the aegis of one organization certainly makes it easier to establish these linkages--as long as all parties are cooperative.

Collaboration is also assisted by the central role of the county Economic Assistance Department in intake. Because most people enter the shelter system through a county-issued voucher, virtually all homeless families must interact with the county staff. In theory, this provides an opportunity for staff to screen for entitlements and link to other mainstream services, although this does not always occur in practice. These links might not exist in other situations where intake is directly to the shelter.

C. Coordination Efforts at the Family Level

Co-location of Services/One-stop Shopping. There were no fully-developed examples of co-location of services or one-stop shopping. In part, this reflects the belief that homeless people have access to mainstream human services. The 410 Shelter is the focus of some co-location of services--the Learning Center, primary health care--and for considerable information and referral services--to education, employment and training, Head Start, AFDC and other entitlements. It is also only a few blocks from the county offices where families receive their vouchers and apply for entitlements.

Case Management. Case management for homeless families in the county social services system is minimal. The AFDC worker is a financial worker. Clients do not have a social services case worker unless there is a CPS or child welfare issue, a mental health issue, or the adult is disabled. In Minnesota, county informants indicated that programming is deep, but not broad; categorical funding is good, but coordinated funding is not.

The shelter system does not do coordinated case management. The 410 Shelter does not provide case managers and has very little ability to track what services the residents need or are receiving. Even the THP programs the site visit team visited are not characterized by aggressive case management, compared with the approaches seen in some other cities.

At the THP level, lack of case management is partly philosophical and consistent with the predominant ideology of client empowerment. Said one THP informant, "Why would we call them 'cases' and why would we want to 'manage' them?" Nevertheless, coordinated service planning in these programs was done mostly through scheduled visits with the staff and suggestions of staff regarding outside agencies that might prove helpful.

Aggressive case management takes place in Minneapolis within specific programs that have decided to extend their role beyond the confines of their programmatic emphases. The education social worker and the staff of HCFH are the two best examples. The education social worker, in the course of linking students to the mainstream school system, does (or intends to do under some new McKinney money) considerable referral to noneducational services including housing, furniture, clothing, and entitlements. He also does follow-up after people leave the shelter. The HCFH staff play a very similar role with clients who see them initially for health-related problems. In the case of HCFH, follow-up theoretically can continue for up to 1 year and involves stabilization services beyond health care needs. In a more informal way, other agencies, such as the Learning Center, and some churches fill some of the case management functions. However, whether or not a family receives this coordinated services planning seems to be a function of which service provider it sees. Similar case management services are provided for women participating in the McKinney Training and Employment Program for Homeless Families at Catholic Charities.

The HUD Project Self-Sufficiency demonstration program funded a project in Minneapolis. The project provided Section 8 certificates to 191 households which agreed to participate in a package of support services and self-sufficiency activities. The Project Self-Sufficiency demonstration program has ended and, in a modified form, components of the project have been continued by the Minneapolis Community Development Agency for other women in public housing. However, no new Section 8 certificates are being issued as part of the modified program, and the team did not encounter this modified program during the site visit.

Follow-up. Follow-up, like case management, is a function of the providers with whom the family is involved. Within the emergency shelter system, follow-up is almost non-existent. In part, families are resistant because they prefer to shake off the stigma of having been sheltered. All informants connected with the emergency shelter system reported that clients often leave suddenly, without leaving a forwarding address. Individual providers such as the Learning Center attempt to stay in contact with the families, but again, the effectiveness of the system depends on the families' willingness to stay in contact.

Of the providers the site visit team interviewed, HCFH was best able to follow-up with clients. As part of the county system it had access to forwarding addresses through the hospital and the county Economic Assistance Department. HCFH follows clients for up to one year after they leave the system. Still, because so many families fail to leave a forwarding address with the shelter, the majority are lost even to HCFH's systems. The education social worker also does some follow-up and intends to expand these capabilities with new grant money. Again, because the education staff's contact with the family is brief--usually 30 days or less--they frequently find that people leave the system and cannot be found.

The THPs have better success with follow-up. Both track their graduates and people who leave the program at 6 months and 1 year. The intent is to see if the person has remained stably housed. In addition, because participants generally have a closer and longer relationship with program staff in the THPs, it is more likely that they will stay in touch with the staff after leaving the program.

Evaluation. Evaluation is not common, although there are isolated program-specific efforts, especially among the THPs. Northwest Area Foundation is undertaking an evaluation of THPs that it has helped fund and is convening a conference to review the results. Passage Community commissioned an evaluation of its first year residents, but that evaluation measured participant satisfaction with the program rather than long-term effectiveness. Elim Transitional Housing, Inc. conducts its own evaluations and measures success as the percentage of families who successfully assume control of their housing at 6 months and 1 year. A few 410 families in each work shift are selected to participate in a survey as part of a Wilder Foundation ongoing study of the homeless services system.

V. System Comprehensiveness

This section presents the service system components and describes how each addresses the needs of homeless families. Within each component is a description of the primary service providers or actors, how services are provided, their comprehensiveness, capacity, and barriers and gaps in service delivery. It should be noted that the following comments are general impressions based on interviews with a limited number of government agency representatives, service providers and advocates.

A. Housing Continuum for Homeless Families

The housing system for homeless families includes emergency shelter, transitional programs, an innovative services-enriched housing model, and permanent housing.

Emergency Shelter. The family shelter system is dominated by the 410 Family Shelter, a very large (270 people) facility in a converted motel building. While informants differ in their feelings about serving homeless families in such a large setting, the general ideology of homeless services in Minneapolis favors alternatives to emergency shelters. The State has endeavored to limit the number of shelters and to focus on transitional and permanent settings. Since 1985, only four new family shelters have been created in the State.

There are 12 emergency shelters in Hennepin County; of these, five county-funded shelters serve homeless families--the 410 Family Shelter and several smaller facilities; two others do not receive public funding.

The county funds shelters mostly through AFDC-EA. County Emergency Shelter Grant (ESG) funds and FEMA Emergency Food and Shelter Grant funds, which come to shelters directly from United Way, are also used. Reimbursement for most of the county-funded shelters is based on a voucher system and a negotiated per diem rate; two are reimbursed under county contracts.

There are several routes of access to the shelter system, but all eventually lead back to the county AFDC financial worker in the Economic Assistance Department of the Family Division of Hennepin County Social Services who determines eligibility for the voucher. Walk-ins are sent to the county financial worker or to a noncounty-sponsored shelter. Red Cross can issue overnight shelter vouchers after hours and in emergencies, but the person is expected to see the financial worker when the office reopens. Several other offices within Hennepin County Social Services--Access Unit, Adult Protection Unit, Adult Housing--are points of entry, but generally route people back through the Economic Assistance Department.

The county voucher assumes a shelter stay of up to 30 days. This is considered to be sufficient time for an AFDC intake appointment to be scheduled and for the client to find housing. If clients find affordable housing, it is in the county's interest to get them out of the shelter; these clients are scheduled for AFDC eligibility interviews that day.

Eligibility for AFDC-EA affects how the new client is processed through the county system. EA is the main source of deposit and security assistance for new housing, although there are a few private sources accessible by the county and United Way. EA-eligible clients are encouraged to look for affordable housing, given some information and referral sources on how to proceed (but very little assistance), and, when housing that meets affordability criteria is found, are given EA for the deposit and moving costs. It should be noted that the figures cited for affordability under EA in Hennepin County--based on local market trends in housing--include monthly rents of up to 80 percent of the monthly AFDC grant amount.

Clients who are not eligible for EA--generally because they have already used it in the last 12 months--go through a different process. These clients must return to Social Services every 3 days to report on the progress of their housing search. If affordable housing has not been located within 3 weeks, the financial worker seeks assistance from the Adult Protection staff who will see if the family has a social services case worker (i.e., for child welfare or adult protection) who can assist the family with housing search and stabilization and will do a brief assessment to screen for issues such as drugs, disabilities, or other issues that might entitle the family to other services or to a social services case worker. The Adult Protection staff member also has access to some private utility and rent assistance funds to aid the family in the transition to permanent housing.

County staff indicate that almost all clients they see are eligible for AFDC in Minnesota or another State.

Family composition does not restrict access to shelter in Minneapolis. Although some of the smaller shelters must place restrictions, the 410 Family Shelter is able to accommodate intact families, families with older male children, and even some large families.

Transitional Housing Programs (THPs). Besides the emergency shelter system, there are several transitional options available. Minnesota was an early pioneer in transitional housing. In Hennepin County alone, there are 11 transitional housing programs that serve women and children, although not all of these target only homeless women and children. Currently, the THPs that accept homeless families include both congregate living and scattered site models. The site visit team visited two: Passage Community, a congregate model THP for 16 families, and Elim Transitional Housing, Inc. which can serve from 75 to 100 people in its various programs. Elim offers several models, the most innovative is of which is a scattered site, services-enriched model in which the client assumes responsibility for the housing after the program goals have been met. However, the organization also operates some congregate facilities and owns some rental units that are part of a more traditional scattered site THP in which the family leaves upon completion of the program.

Emergency shelter and transitional housing programs differ in duration, funding, and characteristics of the population. The average stay in emergency shelter is about 30 days--the intended duration of the county voucher--and funding for the county vouchers comes through AFDC-EA and McKinney (ESG) programs. Most informants indicated that the most dysfunctional people end up in the shelter component.

The duration in transitional housing programs is much longer than in shelters. Both programs the site visit team visited had allowable stays of up to 2 years--although actual stays are much shorter. Funding for transitional housing programs comes from different sources and is much more complex than for emergency shelter. The transitional housing component has tended to use State money and public-private venture money such as the More Than Shelter program. State funding has been channeled through the Department of Jobs and Training (DJT) rather than the Department of Human Resources because advocates want homelessness to be seen as something other than a welfare problem and because, in their opinion, the majority of families do not need social services. In the current biennial budget, DJT has a line item of $700,000 for the biennium for program support and operations statewide. The State Housing Finance Agency has a funding level of $2.5-$3.0 million for the biennium for rehabilitation and purchase of facilities for congregate transitional housing sites statewide. Hennepin County provides funds to THPs; for the congregate sites, this comes as direct grants, but the scattered sites often use it as a rental subsidy.

Family composition does restrict access to some of the THPs. Passage Community does not accept children older than 11 because they do not have the resources to offer the special programming that the staff believes junior high age youth need. Also, they found that there was less neighborhood opposition if the program agreed not to accept older youth. Passage Community generally will not accept mothers less than 18 years of age, but this is not a hard and fast rule. Elim Transitional Housing, Inc., because it offers a variety of models and because its core model involves the family locating its housing, does not restrict access by family composition.

Besides State and local public sources, another program with a funding role in the THP system is the Family Housing Fund (FHF), a joint venture of the McKnight Foundation and the city/county to fund affordable housing. The More Than Shelter program, a subsidiary of FHF, was founded in 1985 as a separate initiative for homelessness. Originally, the program targeted single homeless people, but was expanded to include transitional housing for families. Grants from the More than Shelter Program fund capital development of congregate facilities and also some rental subsidy. Funds are blended with the city's ESG grant which has been totally committed to the More Than Shelter program.

Permanent Housing. According to informants, most people leave both emergency shelter and THPs for permanent housing. For those in emergency shelter, EA funds finance security deposits and moving costs. Besides providing access to EA funds, homeless status also accords priority for public housing and some Section 8 subsidy. However, waiting lists for Section 8 and public housing are far longer than the 30-day shelter stay. There are up to 3,000 individuals on the Section 8 waiting list. Without a Federal preference, waits of two to four years can be expected. Public housing plays essentially no role in housing homeless families; indeed, intakes for families are done only sporadically because so little is available.

The site visit team found that the link to permanent housing was very weak in Minneapolis. Compared with other cities visited, there is very little assistance given to link homeless families to the public housing system. Although there are many non-profit developers of affordable housing in Minneapolis, the team did not encounter any instances of links between the homeless system and these developers. Links between homeless service providers and the public housing authority are among the least well-established of the site visit cities, in part because the average waits for public or subsidized housing are so long. Given the lack of public resources, the team was surprised to find so little assistance with finding private affordable housing. Other than being supplied with a simple list of referrals and some affordability guidelines, families are left on their own to locate private affordable housing. Because the average shelter stay is only 11 days, most families appear to find housing, but advocates assert that they are usually tenuously housed in substandard settings.

Unless families are able to gain access to public or subsidized housing, the affordability problem would seem to doom them to return to the emergency shelter system within a few months. Yet, county data for 1989 indicated that only 10 percent of families received county vouchers more than once in that year. These data do not count those who may have required services in a different year or those who drifted among several substandard settings without seeking county assistance a second time.

Participants in THPs also move from the program to permanent housing. Here, the links to the subsidized housing system work much better because the duration of the program is closer to the typical waiting period for public housing. Indeed, one of the THPs visited expressed concerns that participants were receiving their Section 8 certificates and leaving the program prematurely for fear they would not get another chance at a Section 8 certificate. Both transitional housing programs reported that the majority of clients who left their programs before completion did so because they obtained Section 8 certificates.

B. Health and Developmental Services

Developmental Services. Most developmental services for children and preschool-age children are provided through the shelter system. Although it does not operate services itself, the 410 Shelter encompasses, within the building or through off-site contacts, three major programs for children:

- Project Secure, a targeted Head Start program for children in the 410 Shelter
- 3-4-8 Tots, a county screening and development program
- The Learning Center, a multiservice program for sheltered children of all ages, although it primarily serves those through grade 6.

Project Secure is a component of the Head Start program operated through Parents in Community Action. Access is limited to homeless children in the 410 Shelter, although staff plan to expand access to include one of the other small shelters. Capacity is about 30 children; consequently, there are times when children are turned away. Project Secure has made several modifications to meet the needs of sheltered homeless children. Unlike most Head Start programs, Project Secure is full-day rather than half-day, operates all year-round rather than just during the school year, and serves children ages 6 weeks to 5 years. The program is conducted in a separate room at an off-site Head Start facility. Participants get priority for the mainstream Head Start program operated by Parents in Community Action at the same facility. Two advocates do outreach at the 410 to inform parents about Project Secure. Once the parents leave the program, the advocates do follow-up to ensure they get into the mainstream Head Start program.

The 3-4-8 Tots program is sponsored by Hennepin County and provides developmental screening of children ages 0-3 for learning disabilities and problems in physical growth, vision, and hearing.

Although the Learning Center does not specialize in developmental services, it offers many "hand-to-mouth" services including, among others, providing volunteer nurses for developmental screening for special needs a few nights per month, and a private group which offers play groups and parenting groups on a scheduled basis.

Health Services. The overriding philosophy of service delivery is not to duplicate services but to link clients to the existing mainstream system. In general, health and human services are well-funded in Minneapolis compared with most cities. Nevertheless, there are a few dedicated programs; the most visible is the county's Health Care for the Homeless (HCFH) project. The main role of these special programs is to help homeless people obtain access to the existing service system.

Although it is committed to linking clients to mainstream services, Health Care for the Homeless has developed a variety of special mechanisms to reach sheltered mothers and children. HCFH is located administratively within the Hennepin County Health Department at the Hennepin County Medical Center. The main office is located physically close to the shelters. HCFH considers it to be an advantage to be county administered because it provides access to a wider range of county-funded human services.

Originally based on a public health model, HCFH has adopted a primary care model using mid-level health professionals rather than physicians. HCFH provides services at 13 sites with regular hours at these sites. The 410 Shelter is the main site serving women and children. At this site, HCFH provides primary care, prenatal care, diagnosis and treatment, pharmaceutical services, social work, and financial assistance.

HCFH uses a mobile health care van to provide services at the shelters. At 410, it also staffs a clinic 4 nights per week. The services are staffed by interdisciplinary teams of professionals consisting of both paid and volunteer physicians, nurse practitioners, public health nurses, volunteer nursing students, medical social workers, community health workers, financial workers, and substance abuse case managers.

For services beyond primary care, most health care services are provided through referrals to mainstream medical facilities, especially Hennepin County Medical Center.

HCFH does a great deal of tracking and case management for the homeless families it serves. Indeed, informants indicated that more general case management takes place in the health sector than in any other part of the homeless services system. Because it is part of the Department of Health, HCFH can access medical records at the Hennepin County Medical Center and from the county Economic Assistance Department. This access is especially useful in case management tracking activities. HCFH social workers and financial workers also help families with nonmedical needs such as security deposits, social service needs, housing, and furniture vouchers. Client cease to be a clients when they have been in permanent housing for more than a year or when staff believe that they have been linked to needed ongoing services. HCFH keeps records for 7 years in a computerized database.

Health care professionals working with the homeless are finding that families and children have problems with nutrition, chronic health, immunizations, STDs, prenatal care, and mental illness. HCFH is able to address some of these problems and to link some people to mainstream services in the community.

Mental health services are provided through referral and funded separately but operate as an adjunct program within the county Health Department. If clients are discharged from the hospital but require further bed rest, HCFH links them with community respite beds and provides nursing care.

HCFH's services are funded primarily through McKinney grant funds; its 1990 funding from this source was $570,500. Medical Assistance, the State's Medicaid program, plays less of a role than in some other Health Care for the Homeless programs, in part because of the large number of homeless that are from out-of-State. About half of the homeless clients that HCFH serves are not enrolled, most are believed to be from out-of-State.

C. Education

Preschool. Most preschool educational services were described as part of the Project Secure Head Start program in the Developmental Services section. In addition, the Learning

Center runs a preschool program at the St. Anne's Shelter, a small shelter for women and children. Preschool children from St. Anne's are transported to the Learning Center's satellite facility. Staff of the Learning Center are working to include these preschool children in Project Secure in the near future.

School-age. In the early days of the homeless family crisis, Minneapolis experimented with placing homeless children in the mainstream system. While this worked well for homeless children who were already residents of the county and enrolled in the county school system, it worked poorly for those who were in-migrants. As the number of in-migrants went up, shelter providers and school district officials agreed that the short stay in the local feeder school before the in-migrant homeless children found permanent housing was disruptive to both the mainstream class and the homeless child. In response to this problem, a self-paced transitional education program jointly operated by the Learning Center and the school district evolved. The program is housed at Emerson School, the district's magnet school for all alternative programs, which happens to be located near the 410 Shelter and offers a variety of alternative programs and transitional programs for students.

Again, school placement of homeless children differs, depending upon whether or not the homeless person resided in the school district during the prior 30 days. If the family lived in the district, then the child stays at the school of origin. The social worker at Emerson School arranges with the district's bus dispatcher for the child to be picked up at the shelter and transported to the school of origin each day. Because Minneapolis has an open enrollment system, the bus system is already set up to transport students across town, so accommodating the 410 Shelter students has not required a major departure from common practice.

For children whose families did not reside in the district during the prior 30 days, placement options vary with the child's age. The best developed program is the aforementioned joint program at the school. Children in grades K-6 spend a half-day at the Learning Center; those in grades 1-6 spend the other half of the day in a transitional classroom at the Emerson School. The curriculum for the school portion of the grades 1-6 program is based on the district's home-bound or hospital-bound programs. Lessons are self-contained for each day, and most of the work is self-paced.

Students in grades 7-12 can choose to be mainstreamed if they prefer. However, informants report that the transition is often hard if the family then moves to permanent housing far away from the feeder high school for the shelter. At the time of the site visit, inmigrating students in grades 7-12 were encouraged to attend one of the alternative programs at Emerson School for a trimester and then move to a permanent school. Senior high-age youth were placed in the existing Connections program--a program for students (homeless or otherwise) in transition. However, for junior high-age youth there was no equivalent to the Connections program, and they were assigned to a program for youth with behavior problems. Staff were concerned that these students would be inappropriately labelled once they entered the mainstream system. Since the site visit, a decision has been made to place all inmigrating junior high homeless youth in one of the local junior high schools.

Staff see several advantages to the transitional school setting compared with the earlier attempt at mainstreaming the in-migrating students. In particular, the staff are able to track attendance far better than under the mainstreaming system. This has been particularly beneficial for older students who were often running afoul of the system in their new mainstream schools. More importantly, the alternative school programs give the education social worker time to make contact with the family and establish a relationship that, staff believe, eases the enrollment and transition process to the mainstream school. New McKinney money has funded the salary of a social worker who previously had been paid by the school district money or the Minneapolis Community Action Agency, the parent agency of the Learning Center. In the beginning, the programs concentrated on curriculum, but the staff concluded that they needed a social worker to ease access into the system. Under the old level of funding, the social worker was able to handle outreach to the shelter, clothing, assistance with finding shelter, and also some home visits after students leave the program. The new McKinney funds will allow the social worker to stay in contact with the family after they leave the 410 Shelter until they are sure that the student is connected with the new school's social worker.

The process of entering the mainstream school system is not difficult and is identical to that any other new student would use. For those above grade 3, enrollment is completed through the principal at the school. For those in the elementary grades (K-3), the district operates a Welcome Center (CEPAK) for all new students. The Center provides the mandatory educational testing before registration, although, if school officials suspect the child has special needs, resources can be brought in even without the testing.

Homeless students have a harder time getting access to special education and gifted programs because out-of-State students usually have trouble getting records which might identify special needs in a timely fashion. Obtaining out-of-State records was reported by staff as the single biggest problem in providing mainstream educational services to homeless students. The school district is in the midst of organizing a special project with the Chicago school system--a source of many of Minneapolis' in-migrating homeless students--to send school records of new students by telefacsimile transmission.

Despite the difficulties in obtaining records, lack of immunization documentation is rarely a barrier to school entry. A 30-day waiver can be obtained for most grades, except kindergarten. If necessary, the nurse who works with the Emerson School programs will arrange for a new set of immunizations at the health clinic. The program also works closely with the Learning Center to get immunizations completed for kindergartners at the 410 Shelter before school registration. The clinic at the 410 Shelter and the public health clinics perform preschool immunizations and preschool screenings.

The Learning Center operates school supply programs with the school system and with the Viking Wives, an auxiliary group connected with the local professional football franchise. The Learning Center also has a clothing room from which children can choose school clothes. During the summer, the Learning Center runs a summer program in a private school adjacent to the 410 Shelter. The summer program consists of summer school in the morning and field trips in the afternoon. This program serves students in grades 1 through

6. Unlike most of the other Learning Center programs, the summer program serves children from shelters throughout the city.

At the time of the site visit, one concern of staff at both the shelter and the school district was that kindergartners tend to be left out of educational programs. They were too old for Head Start and too young for the Emerson School program which only serves those in first grade and above. That has since been rectified by providing a full-day program for them at the Learning Center.

After-School. Homeless children in Minneapolis are eligible for an array of mainstream tutoring and remedial programs through the school district. Staff did not know if homeless students used these programs or not; the site visit team did not see any evidence of publicity about these programs. It is more likely that sheltered students participate in the after-school and evening programs for school-age children at the Learning Center. While this is not a tutorial program, the program provides time to do homework, a place to meet with friends after school hours, and relief time for parents. The Center also runs two successful Saturday morning program--one each for older boys and older girls. Volunteers facilitate these life issues groups.

Passage Community, a congregate THP which the site visit team visited, has an active after-school program with a staff member assigned specifically to that task. The program is organized around various themes. The staff member has also established relationships with local churches to run topical evening programs on-site and to work in one-to-one relationships with children.

D. Child Care

As in all the cities visited for this project, affordable child care is the missing piece in the self-sufficiency puzzle for homeless families. The 410 Shelter.is fortunate that the Head Start program is full-day, and can, therefore, serve a child care function; however, women in the other shelters and, especially, women who have recently moved to permanent housing, are not as lucky.

Several shelter programs operate their own child care or have other programs which can also serve this purpose. The Learning Center operates a preschool program off-site for St. Anne's preschool children and an after-school program for preschool- and school-age children at the 410 Shelter and St. Anne's.

At the time of the site visit, Passage Community was operating full-day subsidized child care on-site for ages 6 weeks to 5 years. Approximately half of the children served were children of program participants; the rest were from the surrounding community and service was offered on a sliding fee scale. This program was a financial burden and has since been discontinued. Child care in battered women's short-term shelters is funded through United Way.

Little help with child care is available once homeless mothers move to permanent housing. As in most States, eligibility preferences for subsidized day care in Minnesota resemble those in the Title XX program. This theoretically gives preference to AFDC recipients, job training participants, and special needs children. While the Federal government provides some funding, limits on the amount of money the State is willing to contribute to match the Federal funds restricts the number of spaces that can be subsidized. County staff estimate that only about one-third of families that apply for day care assistance are able to get it; they estimate that there is a 3,000 person waiting list for subsidized day care. Participants in the STRIDE program, Minnesota's response to the JOBS welfare reform program, and CPS special needs children have priority for subsidized slots. Even STRIDE participants have a difficult time getting access to subsidized care because the State has been reluctant to appropriate additional money to match the Federal funds. As a result, STRIDE eligibility criteria have been more restrictively defined to reduce demand to a more manageable level.

E. Other Support Services

Advocates differ in their views about the need for parenting skills. Some believe that the concept of parenting skills, as currently defined, tends to reflect a middle class bias about relationships between parents and children. As some advocates indicated, parents should get credit for keeping the family together and getting the children this far. Nevertheless, parenting skills was a major component of support programs and counseling programs at the shelters and THPs the site visit team visited in Minneapolis.

At the 410 Learning Center, the Early Childhood Family Education (ECFE) program, sponsored by the public schools, provides parent education groups, children's activities, and parent-child activities. Staff of the Learning Center indicated that parenting skills classes are poorly received. Topical sessions such as housing are much better received. Mothers tend to use play groups and quality time groups at the Learning Center as respite care. Indeed, the Center has had to mandate that mothers spend the last half-hour with their children during mother-child groups.

Despite the differing views on the efficacy of parenting groups, all the programs the site visit team visited, set expectations about mother-child relationships. In particular, all prohibited hitting as a form of discipline.

The THPs tended to be more heavily involved in counseling and life skills than were the emergency shelters, probably because shelter stays tend to be too short to pursue extensive counseling.

At both Passage Community and Elim, staff and the participant set goals for life skills. However, neither program provides extensive counseling. In general, participants were referred to outside agencies as needed. The existence of many low-cost social services agencies encourages making referrals rather than providing extensive counseling programs in-house.

F. Employment and Training

Opportunities for employment and training for homeless women with children--or for most AFDC mothers--did not seem plentiful in Minneapolis. However, the team was not able to explore this component of the system in great depth.

One key program is the STRIDE program, Minnesota's response to the Federal JOBS welfare reform, although the degree to which it affects homeless women is currently limited. STRIDE is a joint partnership between the Department of Human Services and the Department of Jobs and Training. In its earliest incarnations, STRIDE was to be seen as a jobs, not welfare, program, but the Federal JOBS legislation requires that the money be run through DHS, and counties submit their plans to both agencies.

The current STRIDE program mandates registration, not participation. Minnesota restricts the definition of the target groups even further than does the Federal government. Targets include those less than 22 years of age (compared with Federal target of those under 24) without H.S. diploma or G.E.D., and people on welfare during 48 of the last 60 months (compared with 36 of the last 60 months for the Federal targets). The program exempts from registration anyone with children under 6 years of age. County staff indicated that many who want to participate do not fall into the target groups. In particular, people over 21 are not eligible to participate unless they have been on welfare for 4 years.

Access to subsidized child care is the biggest incentive for participation. STRIDE will pay for subsidized day care for participants and will also pay for child care for the first year after employment is secured. As was mentioned earlier, STRIDE participation is virtually the only way to access subsidized day care in Minnesota.

STRIDE emphasizes training and education rather than employment. Prior to STRIDE, job training was only part of the client's service package if the financial worker went beyond the call of duty to assemble and include these services.

Under STRIDE, participants are assessed and assigned a case worker. The case ratio is 1:50 versus 1:200 for financial workers. The program covers expenses for transportation, schooling, and job search. Eligibility for Medical Assistance--which would ordinarily be lost if earnings exceeded the limit for AFDC eligibility--is retained into the first year of employment.

The State makes grants to the county, which is the JTPA service area. JTPA, in turn, contracts out to neighborhood agencies. STRIDE case management is done under contracts with community agencies such as neighborhood houses and Catholic Charities; these agencies also conduct job development.

County staff believe that few homeless people gain access to STRIDE. Besides the stress of being homeless and finding affordable housing, many homeless clients are exempt because they have children under 6. Even if they were eligible for STRIDE, it is difficult to develop jobs for homeless women and for most AFDC mothers. JTPA and similar job programs have high job placement goals; these goals tend to discourage them from taking harder-to-serve clients.

There are also some private programs that specifically target homeless mothers. The main program is the Hennepin/McKinney Training and Employment Program for Homeless Families, a 1-year McKinney-funded demonstration program operated by Women and Children in Poverty, a division of Catholic Charities. The program's focus is changing attitudes and motivations about self-sufficiency in addition to providing women with the external resources necessary to achieve independence. The program helps find permanent housing, provides case managed services, and moves willing participants toward employment or training for employment. However, about 70 percent of participants drop-out once housing is found.

G. Other Program Linkages

Child Welfare and Protective Services. As in the other cities visited, homelessness is not considered de facto environmental neglect in Minneapolis. The link to child welfare and protection occurs when the mother has a previous CPS relationship--which shelter providers indicated was frequently the case. In that case, a social services case worker is assigned to the mother. In a loosely case managed system like Minneapolis', the existence of any case worker is probably a benefit in that it gives clients potential access to social services and other referrals that they might not access or know about on their own.

The 410 Shelter and the Learning Center have established relationships with CPS and with St. Joseph's Home. When children appear to be neglected or abandoned by their mothers--rules at 410 require that children be supervised by mothers unless program activities are occurring--CPS is brought in and the child may be taken to St. Joseph's. This does not appear to occur frequently.

As in many of the other cities visited, children who are already in the foster care system are not released to mothers until they find permanent housing.

Entitlement System. While county staff indicate that virtually everyone they screen for shelter vouchers--the main mode of entry into the shelter system--is eligible for AFDC, the high proportion of in-migrants among the homeless family population means that many families, although eligible, cannot receive benefits until their applications are processed. For example, the HCFH staff indicated that one-half of their clientele were not enrolled in Medical Assistance. Nevertheless, Wilder Foundation data indicate that 63.6 percent of homeless families with children had income from AFDC that month and 71 percent had used food stamps. This may reflect the fact that the survey was conducted in February when in-migration is low.

Homeless families are screened for entitlements at several points. Because everyone eventually sees a financial worker to qualify for the shelter voucher, and because the financial worker is also the person who schedules an AFDC intake, in principle everyone should be screened for entitlements at that point. Even if they are missed at that point, all families with a school-age child are screened by the social worker at Emerson School and anyone who receives health care through the Health Care for the Homeless project is screened there.

Respondents believe that many people are not enrolling for Medical Assistance because the enrollment process is difficult, and, for inmigrants, requires extensive documentation. In addition, some nonhealth care respondents reported that fewer and fewer medical practitioners are taking Medicaid clients, especially for dental and eye care, because of the cumbersome billing and reimbursement process. Consequently, homeless families rely by default on the public system and nonprofit agencies and must cope with very long waits for service.

Substance Abuse Service System. The team was not able to spend extensive time examining this component of the system. The shelters can refer to several Narcotics Anonymous and other 12-Step programs. For those who are not eligible for EA and who do not find affordable housing in a reasonable amount of time, the Adult Protection division will screen for problems such as substance abuse, but it is not clear what options they can offer the client if a substance problem is discovered.

Several informants indicated that substance abuse programs for mothers are limited; a crucial need is inpatient treatment programs that allow the mother to keep her children with her during treatment. Currently, only one of these exists in the Minneapolis system.

Mental Health Service System. The team was not able to spend much time exploring these links. Minneapolis--and Minnesota--have fairly extensive systems of Community Mental Health Centers. HCFH staff also indicated that they could refer clients to the McKinney-funded county Access Unit; however, this program really targets chronically mentally ill people.

A key interaction of the mental health and homeless services system relates to the premature discharge of institutionalized clients to the community. As was mentioned earlier, informants believe that this is an important contributor to homelessness in Minnesota. Studies indicate that about one-half of homeless people with mental illness problems were discharged from institutions and do not have community placements. Recent legislation is intended to address this problem, in part, by enforcing caseload limits.

However, informants suggested that mental illness was not a major factor in the homeless family population.

Domestic Violence Service System. Domestic violence is recognized as a factor in family homelessness; most informants indicated that many of their participants had been involved in abusive relationships, either as children or as spouses. However, the system of battered women's shelters and the family homeless system are separate and are funded through different funding streams.

VI. General Issues and Barriers Related to Service Comprehensiveness

Minneapolis' response to the problem of family homelessness has some identified strengths as well as service gaps and other barriers to a comprehensive and coordinated service system. Following is a summary of the major strengths and barriers that were consistently mentioned among several of the site visit informants, and observed by the site visit team.

A. Strengths and Innovative Efforts

To a greater extent than the other cities the site visit team visited, Minneapolis has an established mainstream human services system with which to link homeless families. Consequently, rather than developing a separate system of homeless services, an approach has evolved to link homeless families to the mainstream service system before they get permanent housing. This approach is being used by the transitional education programs, the HCFH program, and Head Start, among others. Although the elements for success are present to a greater degree in Minneapolis than in the other cities visited, its efficacy is open to debate because follow-along and evaluation are not in place. If this approach does not work, then the Minneapolis system is not much different than other cities the site visit team visited--a patchwork of well-intentioned services that serve people in shelters.

More services seem to be available to homeless people in Minneapolis than in other cities visited. In part this is because the 410 Shelter is a magnet for every group interested in linking homeless families to their services and because so many families enter the system through the 410 Shelter. Other factors supporting service linkages include the central role of the county in financing shelters and authorizing access, the relatively small size of the family homeless population, and the relatively small number of major players involved in the emergency shelter system.

B. System Gaps and Barriers

Several informants indicated that funders and the general public tend to have unrealistic goals for the system. They see self-sufficiency programs and THPs as devices to get people off welfare. This is often too ambitious a goal. Problems of many homeless families are so complex and sometimes so severe that 2 years is not sufficient time to resolve all of these issues.

As in most cities, the link between housing and social services, while widely recognized as critical is weakened by differences in target audiences, eligibility criteria, and the level of government responsible for administering services. Linking housing and social services bureaucracies was termed by one informant "an unnatural act performed by two nonconsenting partners." When each side speaks of linkages, they usually mean bringing in additional resources for "their" clients rather than creating a structure of equal/shared responsibility. One of the biggest obstacles is that human services is based on categorical entitlement, whereas housing traditionally is provided on a first-come, first-served basis.

The biggest service gaps in the Minneapolis system include follow-up services, case management, and evaluation. Follow-up is complicated by the fact that many families do not wish to be "followed." Case management reflects both an ideological bias away from managing people and the predominant belief that the elements of the human service system are in place for all low-income people including homeless families. Although many individual evaluation efforts occur at the provider level, these vary in quality and comprehensiveness, and there is no coordinated system-wide evaluation effort.

Most providers interviewed recognize the existence of these three gaps, and if more funding were available, would put these three services near the top of their lists for service expansion. For example, if the 410 Shelter staff had more funds, they would add social workers for more follow-up and stabilization, more links to safe housing, and more jobs and training.

Links within the housing continuum are another gap. Neither THP visited drew clients from the shelter system or seemed to maintain established relationships with them. This is understandable given the sporadic nature of openings in THPs. Even more to the point, there are few links between emergency shelter and permanent housing. The housing authority was less visible as a factor in the homeless service system than in the other cities visited. Although homelessness was said to accord some priority for public housing, there was little evidence of that. Given the minimal link to public housing, the team was surprised to find so few resources directed at assisting people with finding private affordable housing.

Besides these oft-mentioned system-wide gaps, individual informants indicated other program-specific gaps. Health care professionals working with the homeless are finding that families and children have problems with nutrition, chronic health, immunizations, STDs, prenatal care, and mental illness. Some nonhealth care respondents reported that fewer and fewer medical practitioners are taking Medicaid clients, especially for dental care and eyeglasses. Adolescent health care is considered a major gap.

The Minneapolis system is de facto centralized because one shelter facility predominates and because shelter access is coordinated through the county; therefore, information and referral theoretically should work well. However, several respondents felt that there were information gaps about availability of services, particularly if the homeless are not in shelters.

Program Profiles

Minneapolis, Minnesota

410 Family Shelter

Organizational Issues

The 410 Family Shelter was started in 1987. It shares a board of directors and administrative staff with its sister organization, People Serving People, Inc. (PSP). PSP is a multi-service organization serving various homeless populations including a large homeless men's shelter; the McKenna Residence, a program for people with chronic alcoholism; and several other services. The 410 Family Shelter serves only women and children.

The shelter is located in a former hotel/motel building and is the only family shelter site operated by 410 or PSP. The building houses approximately 220 people at capacity and is generally full. It is the largest family shelter in the system. Overflow is sent to some of the other smaller shelters or to the adjacent PSP facility for homeless single men or childless couples. The shelter does not keep a waiting list because of the emergency nature of its services and because intake is centralized at the county which will find alternative places for individuals when 410 is full.

Very little information is tabulated on clients. The 410 staff have noted no major changes in the nature of their clientele except that more in-migrants are coming to the shelter. A more sophisticated client tracking and database system are under development.

Because 410 is housed in a former hotel, the facility is able to accept all types of families and imposes no restrictions on size or composition. Intact families and those with older children are admitted, as are most large families. About half of the children at 410 are under 6 years of age.

Evictions from 410 can be for substance use, violence, or for not supervising children. If children are chronically untended, the staff brings in the county CPS staff.

The mission of 410 is narrowly defined as provision of room and board. The facility is licensed as a hotel and the organization provides no social services of its own, but actively engages in collaborative agreements with others to provide services on-site or off-site. This relationship between 410 and other agencies and its self-definition of its mission have greatly influenced the shape of the Minneapolis system for homeless families.

In 1989, 410 served 889 families and 2322 children; it provided 12,159 units of service to adults and 28,306 to children. In 1990 it served 1,999 children; of those 1,025 were ages 0 to 5 years.

Points of Entry

Residents find out about 410 through word-of-mouth, the county worker, or through the United Way's "First Call for Help" information and referral system, among other ways. While there are a variety of ways of gaining access to 410, eventually all residents are sent to the county Economic Assistance Department for a shelter voucher. A simple intake process is done on new residents. The intake worker also briefs them on the services available through collaborating agencies and the times during which information can be gotten on those programs.

The 410 Shelter is accessible 24 hours per day. It is located downtown near most of the services that families would access such as the county Economic Assistance office, labor pools, and the bus system. Transportation to children's programs is provided by vans and buses. Head Start picks up children each morning. The school system provides transportation to Emerson School each afternoon for the half-day program following the morning activities at the Learning Center. Children are transported to their home school if already enrolled.

Language and cultural barriers do not appear to be large problems. An elevator provides some handicapped accessibility. Spanish speaking staff are available for all shifts and other interpreters are available by phone.

Service Delivery

The 410 Family Shelter provides room and board and free laundry and housekeeping services. The shelter also brings services of other agencies on-site. The most visible of these is the Learning Center, a separate program funded by the Minneapolis Community Action Agency. The Center is housed on the main floor of 410 and serves mainly 410 school-age children with supplementary educational and after-school programs and a variety of other services. The shelter also provides space for a county-staffed health clinic, an advocacy office for the Head Start program, representatives from Legal Aid, and the education social worker who links parents to the mainstream school system. Catholic Charities operates intake for its McKinney-funded employment and training program. There are mental health counselors and county access and financial workers available twice weekly. The Minneapolis Public Schools provide support groups through the Early Child Family Education program.

There is an emergency clothing room. An afternoon, evening, and weekend children's program is beginning. Staff provide some basic housing assistance and some staff are to be trained for domestic abuse and referral.

The two most visible off-site programs which serve 410 residents are Project Secure, a full-day Head Start program for homeless children ages 6 weeks to 5 years, and the transitional programs at Emerson School which serve mainly school-age children who are moving to Minneapolis from other school districts. These include a half-day transitional classroom for children in grades 1-6 which is done in conjunction with the Learning Center and an alternative program for senior high age youth who do not wish to be mainstreamed.

Nothing is mandated at 410, but most families are eager for services, especially for their children. In trying to link residents to services, staff feel a tension between the need for continuity of services and for honoring the family's privacy and right to self-determination.

The duration of the county voucher is typically 30 days; however, vouchers are renewable. County data indicate that the average length of stay for the entire county-funded system is approximately 11 days.

Coordination and Effectiveness of Services

Staff of 410 do not do case planning. If the client has a county social services worker, that person may do some case planning. Many of the services with which the client is involved while at 410--Learning Center, education, health care--will often help refer them to needed services. In general, homeless families at 410 do not receive coordinated services planning. Project Secure (Head Start) provides advocacy, case management, and follow-up after clients leave. The McKinney program also does case management.

Effectiveness is defined as the efficient provision of room and board and the provision of opportunities for other agencies to make linkages to the residents of 410. Effectiveness in terms of ultimate stabilization and outcomes is not tracked. Very little data is kept on clients--most fail to leave a forwarding address. While there is a sense that people rotate in and out of the system, there is little data at 410 to prove or disprove it. No data are kept on where clients go when they leave 410.

Financial Issues

The shelter is financed almost exclusively (95 percent) by money from the county voucher reimbursements. These are based on a negotiated per diem rate with Hennepin County Community Services. The current rate is $16.22 per diem.

The combined 1989 budget for PSP/410 was $2.9 million. Of this, $2.8 million came from the purchase of service contract with the county. About 29 percent of the budget is expended on salaries, wages, and benefits.

Staffing

Staff for 410 include 2 housing service coordinators, 10.6 desk/security workers, a social worker, a family services coordinator, 3 housekeepers, and a houseman. In addition, many general and administrative staff are shared with the other PSP programs. The services on-site are staffed by the collaborating agencies.

Barriers and Issues Identified

The size of 410 has advantages and disadvantages. The advantages are that it meets social needs, permits anonymity for those who want it, and allows economy of scale for provision of social services. The disadvantages are that it creates an institutional atmosphere rather than a home-like environment and sometimes allows people to get "lost" who might benefit from an environment that was more aggressive about services planning.

There is a sense among many informants that emergency shelter, in general, is a dinosaur. The State is committed to finding alternatives and the city has committed its ESG money to the More Than Shelter program. All of this may affect 410 adversely.

The 410 staff report that they would put more effort into follow-along services and stabilization, evaluation, and building links to safe housing and job training and employment.

Elim Transitional Housing, Inc.

Organizational Issues

Elim Transitional Housing, Inc. is the outgrowth of a program which was developed at Elim Baptist Church in Northeast Minneapolis in November 1983. The program incorporated and received 501 (c) (3) status in 1985. The founders of Elim began running a shelter but quickly moved to transitional scattered site housing--they were pioneers in this movement and quickly became the model for many programs in Minnesota. From the start, the philosophy was to keep people in their community of origin and to use existing property.

The mission of the organization is to help people assume stable, independent housing. Elim uses mixed models to reach this goal including shared housing, minimal support programs for those who need help with moving costs or deposits, and the predominate model, extensive support for those who need housing and support services to maintain an independent life.

Extensive support follows one of three models. In the early days of the program, families lived in units rented by Elim and moved on completion of the program. This was expensive for Elim and disruptive for the families. Now the program tries to emphasize a graduated rent subsidy model in which affordable housing is located and services are provided until the family can assume the cost of the unit.

Points of Entry

Clients find out about the program primarily through social service agency referral, word-of-mouth, or through the widespread local and even national publicity the program receives. Intake offices are staffed in Northeast Minneapolis and in Columbia Heights and Blaine, two suburbs north of the city.

Intake consists of a brief overview of the program and a review of the participant's needs. Once the client has found potential housing, they are set up with an advocate/social worker who begins the process of goal setting which is at the core of the contract and process. Intake is a two-part process. The first meeting is with an advocate; the second with the executive director.

The capacity of the various programs is about 75 to 100. They do not maintain a waiting list. The staff readily admit that some "creaming" of clientele goes on and that their participants are not as dysfunctional as those "stuck" in the shelter system. About 25 percent of participants come from the shelter system; the remaining three-quarters were doubled-up or in cars.

Because the program operates a variety of models and because in the services enriched model the client finds the housing, there are no limits on the size and composition of family that can be accommodated. The program is looking for people who are able to live independently and who have a certain level of motivation. The program wishes to identify people before they become too dysfunctional. Elim does not automatically exclude those with a mental illness history so long as they are linked to a program; those with a substance use history are accepted so long as they are practicing sobriety.

The program has had only one eviction--for substance use. More common are 30-day probations, usually for failure to meet plan objectives. The solution is usually to revise the objectives in conjunction with the staff or for the clients to get on track.

Service Delivery

Besides helping the participant find housing and apply for the rental subsidy (Section 8) that will empower many of them to eventually assume control of affordable housing, the service mix varies with the goals set by the client, and advocate/social worker in the "dream sheet" which is the basis of the case service plan/program. The program's goal is not to duplicate services that exist in the community; staff serve the role of "running interference" to link people to the services in the community they need to meet their goals and weekly objectives.

Participants can participate for up to 2 years, but the average stay is 5 months. The participants often assume control of housing independently, either because the goals were accomplished or because they received Section 8 or a job which allowed them to assume the housing cost.

Coordination and Effectiveness of Services

Clients are assessed during the first two weeks and are asked to identify their dreams and goals for the future. The staff work with the participant's dreams and goals and put them into a case service plan--the "dream sheet" which is the key to the process and the contract. The staff then develops with the client weekly objectives. The client and staff meet weekly to assess progress.

Effectiveness is defined as the percentage of participants who move into independent housing. Since 1983 Elim has served more than 5,000 people. Elim performs 6 month and 1 year evaluations of status. About 95 percent of families are succeeding. The rate of success is somewhat lower (85 percent) for single participants, usually because of substance abuse issues.

By the end of the program, about 60 percent of participants have jobs and the other 40 percent have AFDC and Section 8. About 25 percent of participants are in some type of educational or training program.

Financial Issues

The 1991 program budget is $240,000. It draws 25 percent of its funds from Hennepin County and 21.6 percent from earned rents. Families in Elim units pay a graduated rent, generally $200 to $350 per month. Other sources include the State Department of Jobs and Training (6.25 percent), ESG/FEMA (7.9 percent), grants (16 percent), Family and Children's Services (9.9 percent), and income from the Elim moving company (11.4 percent).

Salaries, wages, and benefits represent about 37.5 percent of the budget.

Staffing

The staff include a part-time executive director, a full-time advocate, two part-time advocates, a resource coordinator, one part-time administrative assistant, plus staff of the moving company. Half of the staff are formerly homeless; many are in the process of becoming licensed professionals. The other half of the staff are credentialed. Half of the Board consists of formerly homeless individuals.

Barriers and Issues Identified

Of the population served by Elim, only 25 percent come from the emergency shelter population. The program operates on the northeast side of the city and the northern suburbs--a very different population than that filling the shelters in terms of race, income, employment background, and level of dysfunction.

Staff of Elim see housing programs as a continuum. They see additional need for "dependent" housing--such as congregate model THPs. Although they are committed to the services enriched model, they recognize the need for more congregate models for people with more intensive service needs than their participants. The feeling of community and the ability to focus staff attention are important in these settings; although there is a danger of generating dependency or having participants feed on each others negative attitudes.

The program does not necessarily want to expand, but prefers for others to replicate its model in other communities. Since the clients find the housing, the main barrier to development is a larger operational line item.

It should be noted that the services-enriched model is hard to fit into any of the categories of typical McKinney/HUD funding. The fact that clients will assume control of the unit runs afoul of HUD requirements that the program control the property for 10 years. There are many similar restrictions in Emergency Shelter Grant and Community Services Block Grant funding. Thus far, Elim prefers not to change the services-enriched model even though it restricts its ability to attract funding.

Passage Community

Organizational Issues

The program is a subsidiary of Women's Community Housing, Inc. (WCH) which grew out of the battered women's movement and a concern about the lack of affordable housing for women coming out of crisis situations. The founders believed there was a need for a community that provided and encouraged support and economic independence for low-income single parents who may be battered, displaced homemakers, or recovering substance users. The program renovated an apartment building into a 16-unit congregate facility. The program has been based in that building--a former drug house--since July 1986.

Capacity of the program is 16 families. There are three one-bedroom apartments, six two-bedroom apartments, and seven three-bedroom apartments.

A status report for March 1989 indicated that of the 16 women enrolled, 12 were in full-time school, work, or a combination.

Points of Entry

The program is for low-income female heads of households; the target group is women with children, although they do accept single women without children. Passage Community is looking for motivated women who have "some plan for change" and are able to identify goals and make continuous progress toward them in education, employment, on-the-job training or upgrading present skills. Substance use on the premises is cause for eviction, but the policy of the program is to be "chemically-safe" rather than "chemically-free." Women with prior substance use problems are admitted but must have demonstrated 6 months of sobriety. Use of alcohol is tolerated, as long as it is prudent and reasonable.

Typically, clients find out about the program through agency referral and word-of-mouth. Clients have come from shelters, battered women's shelters, and substance abuse programs among other sources. At one point there was a long waiting list, but an update indicated that most people on the list had found housing. Currently, there are 10 to 12 families on the list.

Besides on-premises substance use, clients can be evicted for nonpayment of rent, violence that threatens others, and for administrative reasons--typically, failure to make progress on their plan.

Service Delivery

A contract, which defines self-sufficiency goals and objectives arrived at in conjunction with the staff, is at the core of service delivery. At the time of the site visit, the program included an on-site day care center; however, it was eliminated in January 1991 because of budget limitations. Some funds are available to subsidize the enrollment of children in child care at other sites until the parent can find other sources of payment for child care. The program also has an after-school program for children ages 5-13, parent-child workshops, and assorted self-help and issues groups.

Participation in Passage requires continuing participation in education, employment or training, provision of quarterly reports, maintaining all scheduled appointments, and attending twice monthly meetings.

Clients can stay for up to 2 years, and the average stay is about 18 months. The program gets the client's name on the Section 8 lists as soon as possible after entering the program, and most who leave before 2 years do so because they received Section 8 certificates.

Coordination and Effectiveness of Services

The focus of case planning is on goal planning and helping the client implement these goals. The primary goal is economic self-sufficiency. Everyone has a written action plan for implementing the goals, but the content is flexible. Usually, the staff role is to provide information and let the client select her goals.

Staff see the purpose of the program as building cooperative living skills and educational and other life skills. They do not expect women to have met their goals by the end of the 2 years, but rather to make incremental gains toward economic self-sufficiency and family stability.

Evaluation is not routinely done. The former director knew about progress in an anecdotal way. A formal evaluation was conducted by a researcher at the University of Minnesota based on the first year's clients, but it measured participant satisfaction with the program rather than the number of satisfactory outcomes.

Financial Issues

Clients pay based on the HUD criteria of 30 percent of income after exclusions. The MHFA subsidizes the difference between the market rate rent and the actual rent. Current rents are $170 for the one-bedroom, and $251 for the two-bedroom; the three-bedroom rate is set according to a HUD formula. The program also receives some money from the More Than Shelter program.

The 1990 budget of $225,840 includes 63 percent from foundations and corporate philanthropy, 20 percent from the county, 12.3 percent from the State, and about 2.4 percent each from Federal sources and individual donations.

About 60 percent of the budget is expended on salaries, wages, and benefits.

Staffing

The staff include an executive director, program director, child program director, .75 FTE office manager (paid for by the parent organization), and .25 FTE property manager (paid for by the property management company). In addition, the day care center has a director and four to five FTEs and a .5 FTE cook. Maintenance is provided through the property management company.

Barriers and Issues Identified

The Section 8 certificates are frequently awarded prior to completion of the program because those participating in self-sufficiency programs are accorded a Federal preference. Because they are so rare, women feel compelled to use them when they receive them. Consequently, in the opinion of the staff, many families leave the program prematurely. They would prefer that certificates were awarded with some flexibility in the use date.

Follow-up and evaluation are the two biggest needs. Day care, while an important service, was a drain on the budget.

Emerson School Transitional Programs

Organizational Issues

The Emerson School site, which houses the Emerson Transitional Program for children of homeless families, is also the location of several alternative educational programs. These programs include a program which serves severely learning disabled students, two secondary drop-out prevention programs (the Connections Program, the P.M. High School), and the Junior High Alternative Program for students with behavior problems.

From the onset of developing educational programming for children of homeless families, the Minneapolis Schools has been committed to mainstreaming homeless students whenever possible. The district has successfully maintained the enrollment of nearly every student whose family becomes homeless while already enrolled in a Minneapolis school. The greatest majority of these students continue their enrollment at their original school. For students newly arriving into the city and school district, it was apparent that a transitional or temporary program offered more continuity and would minimize the disruption for those students who would otherwise have to enroll in a temporary school and change schools again as soon as the family located permanent housing.

The current educational service model in Minneapolis provides several alternative educational programs and resources for those in-migrating families with school-age children who are residing in the 410 Family Shelter. This shelter is the primary receiving shelter for families with children in the Minneapolis area.

- A half-day transitional program for students grades 1-6. Students attend morning educational and recreational activities at the homeless shelter-based Learning Center. In the afternoon, students are bused to the Emerson Transitional Program. At Emerson, students attend classes from 1:00 to 3:30 p.m., Monday through Friday.

- Both junior and senior high students may be initially mainstreamed if they prefer. Junior high students who choose not to be mainstreamed are enrolled immediately in the Anwatin Junior High School, a receiving secondary school for all homeless students. Senior high students are extended the option of enrolling in the Connections program, an alternative program for secondary students.

In the early phases of developing educational services for students, effort was concentrated on finding resources, i.e., books, curriculums, location of a classroom, teacher, and the basics that would get students back into a normalized school atmosphere and routine. After this was accomplished, the district turned its attention to another area of unmet need, a centralized support person or social worker who would serve as the central link to quickly intervene with every homeless student and offer immediate referral and access to a mainstream public school resource.

Points of Entry

An MSW social worker provides outreach services at the shelter to every family with school-age children. This staff person is full-time and is housed at the 410 Family Shelter. He is now assisted by a full-time outreach paraprofessional who works at the shelter.

The Emerson School transition classroom is open to all children from the 410 Family Shelter and to children residing at St. Ann's Shelter, a program in North Minneapolis. The outreach services are offered to all school-age students, including those who attend the Emerson transitional program and those who are eligible for junior high or senior high school. It is readily accessible to the 410 Shelter. Transportation is provided by the school district between 410 and Emerson School.

Service Delivery

For those families at 410 who are already enrolled from the district, the social worker's main task is to arrange bus transportation so the child can stay in their home school. This system is currently working well since the city has an open enrollment policy. Both the social worker and outreach worker provide referrals to community resources to assist families in their efforts to locate new housing, clothing, furniture, or other resources that will help them.

For those students who are new to the district, the social worker and the outreach worker provide immediate links to the Emerson School program and the school system's Welcome Center, a centralized enrollment center for all students new to the district and from which a permanent school will be assigned. The Minneapolis Public Schools also provide a team of nurses who conduct health and developmental screening for children ages 3 to 5 years. This service is available every other week, one evening weekly from 4:30 to 8:00 p.m.

Much of the social work activity at this juncture is to assist entry into the district. Assisting the family to secure educational records from the former school, arranging for immunizations and educational screening or assessments, linking the family to the Welcome Center, to their entry school sites, and assisting with any enrollment task, are seen as priority services.

The transitional classroom is a self-contained classroom in which students in grades 1 to 6 are initially screened to determine basic academic skill levels. Students then work at their own pace within individualized lesson plans that reflect the student's grade level or level of academic readiness. Lesson plans are designed for daily completion. There tends to be rapid turnover of students in the transitional school program since they attend the program only while their families are residing in the 410 Family Shelter. Their average length of stay is about 10 to 14 days. Students are encouraged to enroll in and attend their permanent school immediately upon discharge from the shelter. All of the needed arrangements and connections for permanent school enrollment take place during the student's temporary shelter stay.

The programs' educational and social work staff link with other district programs and resources to serve those students who have special needs. This would include students who exhibit special learning or handicapping conditions and those students who exhibit special talents or skills.

The model for delivering services for families residing at the shelter is one of immediate intervention, offering tangible short-term services that will quickly facilitate school enrollment. All case planning is focused on return to community living. Referrals are made as needed to secure housing assistance, legal assistance, clothing, furniture, and other types of assistance that will stabilize the family's life in the community.

While at the shelter, the social worker and outreach worker assume active roles in encouraging families to attend, the weekly parent support groups at the shelter provided by Minneapolis Public Schools' Early Childhood and Family Education program.

Effectiveness is defined as providing a stable educational environment while the child is in transition into the mainstream school system. All students who leave the shelter are followed up to verify that school enrollment does take place within their permanently assigned school. Social services to the family terminates when it is verified that the family has secured housing and that the student has enrolled in school. Families are encouraged to call back if they need further information or assistance.

It is hoped that a new McKinney grant will fund additional follow-up activities that may yield better data on program effectiveness.

Financial Issues

The social worker and instructional programs are funded from the school district budget. The social work aide, parent support group, and preschool screening are funded from a McKinney grant. Actual cost of some aspects of the program are difficult to ascertain. When students are immediately programmed into a mainstream school, i.e., a junior or senior high school, for example, program cost is not readily apparent.

Staffing

Besides the full-time social worker, there is a full-time social work aide and a full-time teacher for the transition classroom. This teacher is assisted by a full-time and a part-time classroom aide. A variety of other Emerson School staff spend part of their time with the homeless children and youth, but it is difficult to determine the exact time dedicated to the homeless program.

Barriers and Issues Identified

Initially, kindergartners fell through the cracks, being too old for Head Start and too young for the classroom. Currently, any child who is too old for Head Start and not in first grade, is eligible for a full day at the Learning Center.

Programming changes now allow junior high students to be placed in a mainstream school. Earlier they were temporarily placed in the Junior High Alternative Program located at the Emerson-site.

While it was never envisioned for Minneapolis Public Schools to provide a full-day program at the transitional school, there is even less impetus now to consider this as an issue due to the rapid school enrollment for new students and the continuity of education for those already enrolled.

The Learning Center

Organizational Issues

The Learning Center is a program of the Minneapolis Community Action Agency and is housed on the ground level of a newly renovated area at the 410 Family Shelter. In the 410 facility, the Learning Center serves mainly school-age children from the 410 Family Shelter. Recently, the Learning Center opened a satellite facility in a building nearby. This facility serves preschool and school-age children from St. Ann's Shelter, a nearby shelter for women and children, and overflow from the 410 facility.

The Learning Center was founded in the summer of 1988 as a recreational summer camp program called "Young Explorers," for children in shelters in the Twin Cities. The program subsequently received another grant for a school-year program. The program worked to establish linkages with the Minneapolis Public Schools and made arrangements for sheltered children to attend public schools in their own neighborhoods. An estimated 40 to 50 percent of all sheltered children attend the Learning Center.

Points of Entry

Access to the Learning Center is limited to children from the 410 Family Shelter and, more recently, from St. Ann's Shelter. On intake, the family is informed about the services. Intake to the Learning Center is done each morning on a first-come first-served basis. It is not uncommon to turn people away, although the satellite facility has eased the capacity constraint. St. Ann's children are transported by van to the satellite facility.

Service Delivery

The main emphasis of the Learning Center is a series of supplementary educational programs. The most visible of these is a full-day program for school-age children in conjunction with the Emerson School. Kindergartners stay at the Learning Center all day; students in grades 1 to 6 attend the Learning Center for morning activities which consist of reading time and thematic arts and crafts. The students are transported to the Emerson School for the afternoon program which is a more traditional curriculum.

The Learning Center also runs an after-school program for school-age children which consists of general activities, time and space to do homework, and respite for parents. In the evening, the Learning Center runs programs for families and children. On a scheduled basis it brings in speakers, runs play groups, and does assessments and screenings. A similar program for older youth is conducted on Saturdays.

In addition to its educational programs, the Learning Center offers school supplies through volunteer fundraising, clothing for school children, and some other services including housing resettlement services.

In the summer, the Learning Center operates a summer school program for children in grades 1-6 from shelters throughout the city. This program is housed in a nearby private school and consists of morning academic sessions and afternoon field trips and recreational activities.

Services are provided so long as the family is housed in the shelter. Average shelter stay is 11 days.

Future plans include the following:

- A mentorship program, pairing high-risk students with community leaders.
- The Support, Outreach, Stabilization (S.O.S.) program, which is a follow-up program for families.

Coordination and Effectiveness of Services

Some informal case planning is done by the staff of the Learning Center. Also, the staff have put together a resource guide which is distributed to all families. Many of the speakers and groups are related to life and service issues; as such they help fill some of the case planning and resource identification needs of families.

The staff tries to track families after they leave the shelter, but does not have much follow-up information. Effectiveness is not defined or measured in a routine way.

Financial Issues

The program is funded through the Minneapolis Community Action Agency, a department of the city. The annual operating budget is $155,000. Financial sources include:

- McKinney - CSBG Supplemental Funds (30 percent)
- McKinney - CSBG Discretionary Funds (30 percent)
- Emergency Housing Program (20 percent)
- M.E.O.G. (10 percent)
- Private Funds (10 percent)

Staffing

The staff includes a full-time executive director, a full-time program director/teacher, a part-time teacher, and two full-time teachers aides. In addition, the program can draw on a variety of volunteers.

Barriers and Issues Identified

The city relationship has advantages and disadvantages. It provides administrative support and clout, but the city system makes it very difficult to get changes approved, to get flexibility in use of funds, and to fundraise.

Project Secure

Organizational Issues

Project Secure is a special Head Start Program serving those homeless infants, toddlers, and preschoolers residing in the 410 Shelter. The program is operated by Parents In Community Action, Inc. (PICA), out of PICA's Early Childhood Family Development Center in Minneapolis. Project Secure is licensed to serve 30 children ages 6 weeks to 5 years.

The impetus for the program stemmed from concern about the lack of services available for homeless preschool-age children. Staff saw increasing numbers of homeless children in Catholic Charities drop-in centers and noticed parent(s) frequently toting their young children along while applying for AFDC certification and other services, including permanent housing. Many of these children, while eligible for Head Start, were unable to attend the program because of lack of available slots; currently 1,300 children in Minneapolis are on the waiting list and no outreach for the program is performed.

The goal of Project Secure is to provide homeless preschool-age children and their families with comprehensive services on an interim basis. Once families leave the shelter and enter permanent housing, the children are given priority enrollment in a regular Head Start program, also run by PICA.

Points of Entry

The point of entry for the program is the 410 shelter. A Project Secure advocate is stationed on-site on a regular basis. In addition, fliers are handed out to families upon daily intake to the shelter.

Children ages 6 weeks to 5 years, residing in the 410 Shelter, and meeting the Head Start guidelines are eligible to participate. Project Secure is licensed to serve a total of 30 children on a daily basis: 15 preschoolers, 7 toddlers, and 8 infants. At times, the demand for the program has exceeded the number allowed and staff has had to turn children away--however, this appears to be rare. The program intends to expand its intake to include at least one other family shelter.

Service Delivery

Children and families in Project Secure receive education, social services, parent involvement programs, services to children with handicapping conditions, and services in health, nutrition, and transportation. To be eligible for the program, children must meet the guidelines for regular Head Start. The program is open Monday through Friday, from 8:30 a.m. to 3:30 p.m.

The basic services provided are as follows:

- Transportation. Drivers trained in child development transport the children to and from the program and to other program activities. Parents are also transported as necessary. Older children (age 3 to 4 years) are picked up at 8:30 and returned at 3:00, while younger children are picked up at 9:00 and returned at 2:30.

- Advocacy and Parent Involvement. Two full-time advocates work with the families to assess their needs and to locate permanent housing and other necessary services. One advocate works to enroll the family and monitor progress in the program, while the other provides follow-up with the families as they leave shelter, helping the children access regular Head Start. Depending on the family's particular needs, the advocates provide referral, support and follow-up to solve financial and legal problems, and to meet medical, dental, social/psychological, material, and educational needs. Many of these services, such as health care, involve referrals to outside organizations such as Health Care for the Homeless. Other special services for parents include twice monthly meetings, special events, and bake sales, and some informal counseling. The goal of these activities is to strengthen the parent's role in the family in order to facilitate the transition from homelessness to permanent housing.

- Education. Children are provided the same educational services as in the regular Head Start program. Self-esteem, self-help, problem-solving, and choice-making skills are emphasized.

- Health and Handicap. The program performs daily health checks, developmental assessments, and screenings to identify special health or developmental problems. They refer the children to a variety of different child development programs in the County when problems are discovered. In addition, the program ensures that children are immunized through its referral relationship with Health Care for the Homeless.

- Nutrition. The program provides two-thirds of each child's daily nutritional needs. Infants receive formula, juice, and baby food according to their individual needs. For toddlers and preschoolers, meals are served family style.

In general, children and parents participate in the program for a short period of time, depending on their length of time in the 410 Shelter. Families' participation in the program ranges in length from 1 to 29 days, with an average stay of 8 days.

Coordination and Effectiveness of Services

The two advocates have major responsibility for providing case planning services in addition to the comprehensive services that Head Start participants regularly receive.

Program staff refer to both anecdotal and outcome data to document the program's success. Anecdotally, they find parents very positive about the program during a time when stress levels are often high. Service statistics indicate that Project Secure served 506 unduplicated children in its first year of operation (1989 to 1990). The average number of new children served each month was 42, and the average cost per child, $484.85.

Staff have found that families with three or more children have the most difficulty locating permanent housing and moving from shelter. Of the 506 children leaving the shelter, only 21 became homeless again, to their knowledge. The main causes of subsequent episodes of homelessness are housing condemnation and domestic violence.

Finally, the program service statistics show that a greatly disproportionate percentage of program clients are minorities: 93 percent of Project Secure clients and 90 percent of 410 Shelter residents are minorities. In Project Secure, 84 percent were African American, 7 percent white, 6 percent Native American, and 3 percent Hispanic.

Financial Issues

The program is funded through State Head Start funding (flexible funding set aside for innovative services) and foundation and private dollars. The annual program operating costs are $250,000.

Staffing

Staff includes 1 director, 2 advocates, 4 infant/toddler teachers, 2 preschool teachers, and 1 driver.

Barriers and Issues Identified

The program reports that services for infants and toddlers are a major service gap in the city. Although the program is unable to link these younger children to Head Start because of their age, they try to get them into services where available and attach them to regular health care services.

Staff identified two major barriers to linking homeless children to regular Head Start services. The first is that Head Start program funding is inadequate to meet the demand for services; in Minneapolis, only 10 percent of eligible children are served. The second is that Federal funding regulations require programs to keep track of average daily attendance, and to conduct both complete medical analyses and follow-up on participating children in order to receive funding. Because of the transiency of homeless children, meeting these requirements are difficult, if not impossible. Many programs would like to serve homeless children, but they need more flexibility (waivers) in order to do so.

The flexible Head Start funding available from the State was the key to the creation of Project Secure. However, creative packaging of funding is often difficult; program funding success is often against great odds.

Hennepin/McKinney Training and Employment Program for Homeless Families

Organizational Issues

The Hennepin/McKinney Training and Employment Program for Homeless Families is operated by the Division of Women and Children in Poverty within Catholic Charities. The program is a one-year, McKinney-funded demonstration to stabilize and train homeless adults. Catholic Charities chose to focus on providing these services to homeless families with children, the overwhelming majority of which are female-headed.

The program's basic service philosophy is that self-sufficiency is often as much a state of the mind as it is a fact. Consequently, the program focuses on helping clients change their attitudes and motivations about self-sufficiency in addition to providing them with access to the external resources necessary to achieve independence.

The program began in May 1990. Program staff describe participants as multi-problem. The average family served has 2 to 3 children. Seventy percent of clients are in-migrants from outside of the Hennepin County area. Nearly all of the women served are under age 35 and are almost exclusively African American. Many women have experienced domestic violence and abuse. Most are long-term recipients of public assistance. Preparedness for employment is extremely low; most women test at the 5th grade level and have no work history.

Points of Entry

Access to the program is through emergency shelters. Initially, the program performed outreach to shelters; however, as the number of program participants increased, new clients starting finding out about the program through word of mouth. All program services are provided in one, multi-service center.

The McKinney Homeless Families program is located at the same site as the STRIDE program, Minnesota's response to the Federal JOBS welfare reform program for AFDC recipients. Unlike the Hennepin County McKinney program, STRIDE does not serve homeless women. However, because the programs are co-located, they share resources such as child care, and therapeutic and testing services. Having the serves co-located eases the strain on mothers who otherwise would have to take buses all over the city to access the various services they and their families need each day in order to hold a job.

Service Delivery

After the initial intake with the family, the program pursues three major goals: (1) finding permanent housing for the family, (2) providing case managed services, and (3) moving the parent(s) toward employment or training for employment.

More specifically, the program provides the following array of services:

- Permanent housing. The program helps families find permanent housing, rather than shelter or transitional housing, although it is often difficult to find permanent, affordable housing that is not substandard.
- Assessment. The assessment services involve vocational and academic testing and the identification of appropriate job training or job programs.
- Job training and employment programs.
- Support services. Families have access to on-site day care, therapeutic services, support groups, and money for transportation and other incidentals.

The length of participation in employment and training varies with the needs and motivation of the participant; however, the program follows up with clients for a period of 26 weeks after the termination of participation.

Coordination and Effectiveness of Services

After the initial assessment and testing, the program develops an individual employability development plan (EDP) with the head of the family. The EDP helps to identify potential barriers to employment. Removing these barriers, however, is often difficult. Case management contributes toward resolving the family's immediate and short-term crisis (homelessness and problems with health, safety, clothing, food, and transportation), creating the idea and motivation toward self-sufficiency (defining obtainable objectives), and helping the family complete training and/or job development.

The goal of the program is to place clients in jobs that allow for self-sufficiency, which according to the program, requires an income of $7.00 per hour or more. The program has a high number of dropouts -- 30 percent go on to participate in long-term training or jobs. This is largely because after families are assisted with finding permanent housing, they often feel their major need has been addressed.

In the program's first three-quarters of a year, out of 162 families, 17 women were placed in jobs; 48 will be placed by the end of the year. The average salary for these placements in $6.05. In addition, 4 women are in long-term training and 1 man is studying to be a bookkeeper.

Financial Issues

The program received $404,000 for the year from the Department of Labor, McKinney program funds; and another $82,000 from Catholic Charities.

Staffing

Staff includes 1 program manager, 2 case workers, and the staff working with the various on-site services (the STRIDE program, GED, employment and training, day care, support groups, and therapeutic services).

Barriers and Issues Identified

Program staff find McKinney's flexible funding to be very effective for serving the homeless--funding can be used to pay for shoes, driver's licenses, bus tokens, relocation expenses, and other necessities. On the other hand, mainstream, categorically-funded employment and training programs are in many ways too inflexible to serve the homeless. They often require proof of AFDC participation, which in Minneapolis is a problem since so many of the homeless are in-migrants from other cities. In addition, they do not address the start-up costs that the homeless have.

The employment barriers for women with children are much greater than for single women. The main reason is the existence of children. A single woman may be able to afford to take a job that pays the minimum wage, while a woman with children needs subsidies for child care, health care, and transportation, among other things. These needs have implications for the length of time that women with children will need assistance in order to become self-sufficient; without these services, many women will not be able to retain their jobs.

The program director identifies the following services as essential for a comprehensive employment and training program for homeless families: housing resource access, emergency funding, emergency food services, transportation voucher dispersement, drop-in child care, on-site GED and ABE classes, therapeutic groups and counseling, peer counseling and support services, parenting classes, and social welfare advocacy.

Hennepin County Community Health Department
Homeless Assistance Project

Organizational Issues

The Homeless Assistance Project is a McKinney-funded Health Care for the Homeless project. Although administratively within the Community Health Department, the project is an interagency effort involving the Minneapolis City Health Department and Hennepin County Medical Center. The function of the Homeless Assistance Project is to provide health care services to homeless individuals and families through health clinics at emergency shelters, drop-in centers, and other community-based facilities in the downtown Minneapolis area.

As of November 1990, the project had been in operation five years. When originally conceived, the project had a public health nursing focus; it has subsequently adopted a primary care focus, relying on mid-level nursing professionals rather than physicians as the primary service providers.

Points of Entry

Health care services are provided one or more times weekly at six emergency shelters, five drop-in centers, one board and care facility, and one food program. Most of the homeless families served receive health care at the county-funded shelter for families, the 410 Family Shelter.

Services are provided 4 times per week for a half day. Families may be referred to the clinic a number of different ways. Upon intake to shelter they are told about the program and may come on their own accord. Nurses may seek out a family after being told by front desk staff about a health concern within the family. Or, nurses may visit a family at the shelter after identifying it as new from the daily shelter intake printout. In most instances, families are contacted within 24 hours of arriving at the shelter.

Service Delivery

The Homeless Assistance Project provides health, social services, and financial assistance to individuals and families. Services for families and others include primary and mobile health care; diagnosis and treatment; chemical health case management; pharmaceutical services; case planning, counseling and other social work assistance; and financial assistance. Services for children include well-child checkups, immunizations, and a limited number of developmental assessments.

Homeless Assistance Project services are provided by a multi-disciplinary team of professionals consisting of a both paid and volunteer physicians, nurse practitioners, public health nurses, volunteer nursing students, a medical social worker, a community health worker, a financial assistance worker, and chemical health case managers.

Because the Homeless Assistance Project is located within the County's Community Health Department and the County is the primary provider of health and human services, it is relatively easy for the project to refer families to mainstream county-funded services. Health care workers refer clients to the Hennepin County Medical Center, Indian Health Board of Minneapolis, and Pilot City Health Center.

Families requiring chemical dependency treatment are referred to the Minnesota Indian Women's Resource Center for chemical health assessments and referrals to chemical dependency programs. The Mental Health Project, a separate McKinney-funded project within the Hennepin County Community,.Services Department, works closely with Community Health Department staff to provide mental health consultations. Finally, the project's financial worker refers clients to Hennepin County Social Services for AFDC and Medical Assistance.

Service duration is usually tied to shelter residency, which, in Minneapolis, is typically 30 days. However, the program will serve individuals and families for up to one year after they are permanently housed.

Coordination and Effectiveness of Services

According to several service providers, the Homeless Assistance Project is the major avenue for case management services to the homeless in the Minneapolis area. As described above, the project offers a wide variety of services in addition to referring families with more acute or specialized needs to outside agencies or organizations. Besides performing outreach to achieve the initial link to services, project staff assess the family's need for these services, and if necessary, refer the family to other services and then track whether or not the service is actually received. To assist in their efforts to track the families, staff use a tracking form that allows them to give a copy of the referral form to the client, while keeping one with the project. Project staff later check to see if the appointment was kept. If missed, and the situation appears urgent, staff will follow-up with the family.

Follow-up is often difficult. Families frequently leave the shelter with no forwarding address. In these instances, staff may try to track families using information from the county economic assistance programs. Also assisting their tracking efforts is the agreement with Hennepin County Medical Center to share medical records. In addition, when clients use private hospitals, project staff can often access parts of their medical charts. Primary medical records are stored in a database located in the project's administrative office and kept for up to seven years.

The goal of the Homeless Assistance Project is to follow families until they have been permanently housed for a year. In reality, this is often difficult because families are so difficult to track or they may be reluctant to return to shelters to receive their health care services because of the stigma attached to shelters.

The Homeless Assistance Project collects detailed data on service delivery. In the first half of 1990, primary health care, preventive health care, and follow-up health care services were provided to 1,793 unduplicated individuals. A total of 4,504 primary health care encounters were recorded during this period.

The project has also collected information on the effectiveness of its case management services. Nearly 50 percent of 143 clients receiving case management services were housed and remained stably housed six months later. (These clients were all chronic recidivist alcoholics.) In 1990, the project's financial worker obtained housing for 82 families and referred 714 families to housing, despite the fact that this worker's main responsibility is to link families to public assistance programs. Finally, also in 1990, the Homeless Assistance Project successfully linked 171 pregnant homeless women to prenatal care services.

Financial Issues

The Federal government and Hennepin County share the funding responsibility for the Homeless Assistance Project. In 1990, the Project received $570,500 in Federal McKinney funds and the county contributed $395,305, for a total of $965,805.

Staffing

Project staff includes 4 FTE nurse practitioners, 6 FTE public health nurses, a .75 FTE social worker, 1 financial assistant, 1 community health worker, 1 project supervisor, and a .2 FTE medical director. In addition, the project uses volunteer physicians and nursing students.

Barriers and Issues Identified

Project staff estimate that up to one-half of all the women they serve are not enrolled in Medical Assistance. They believe this is because about half of their clients are from the greater Minnesota area or are recent migrants from outside the State.

Staff feel that locating services on-site in shelters is both advantageous and disadvantageous. The advantage is that it is easier to access clients. The disadvantage is that because shelters often have a negative stigma attached to them, after leaving the shelter families are often reluctant to return to them for services, thus hampering follow-up efforts.

Every effort is made to keep the same staff at the same site each week in order to have more continuity of care for the clients.

Project staff identified a number of gaps in the health care system for homeless families in the area.

- Adolescents often fail to get the health care services they need because in order to get on Medical Assistance minors must be emancipated and willing to comply with the application process. The application process may require them to provide information they do not wish to share.

- There are few chemical dependency treatment programs in the Minneapolis area that are suited for women with young children.

- Finally, staff indicated that they would like to have economic assistance eligibility workers on-site during clinic hours in order to reduce the waiting time between intake and the first health care appointment. However, at this point this is not possible.

Chapter V

Site Visit Report

Oakland, California

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Chapter V. Site Visit Report--Oakland

I. Introduction

Oakland was selected for study based on geographic representation considerations, the size of the family homeless population, and because of the city's strong, nonprofit provider community. The site visit team was interested in seeing how homeless services were linked in a system where non-profit, rather than public, service providers predominated. In particular, the study team was aware of several strong, comprehensive programs at the county and individual provider level that offer homeless families a wide-range of comprehensive services. Finally, the study team wished to examine how the October 1989 Loma Prieta earthquake affected the delivery of homeless services in a city whose housing system was already overburdened.

II. Overview of Site Visit

The Macro study team visited Oakland on December 12-14, 1990 to explore how the city's existing programs and service delivery system were meeting the needs of homeless families with children. Many of the key players in the service system for homeless families were interviewed. They included representatives of county and city government agencies, advocacy groups, and service programs. Where possible, the service programs were toured.

The following officials from State and city government offices were interviewed about their involvement in the delivery of services to homeless families:

- Oakland Housing Authority, which manages 3,300 public housing units and 7,000 Section 8 certificates in the city.
- Alameda County Social Services Agency, the funder of last resort for welfare and child protective services.
- County Homeless Coordinator, Office of the Alameda County Administrator, which coordinates homeless services at the county level.

Advocacy groups interviewed included:

- Emergency Services Network of Alameda County, a coalition of 130 members from the public and private sectors working to eliminate homelessness.
- Berkeley Oakland Support Services, both a homeless service provider and an advocacy organization.

In addition, the study team interviewed program staff and toured the facilities of the following programs:

- Health Care for the Homeless, Alameda County Health Agency, the largest county organization providing health services to the homeless.
- Berkeley Oakland Support Services (BOSS), the largest, non-county organization providing emergency, transitional, and long-term direct services to the homeless. The study team visited the Berkeley Multi-Service Center and Harrison House Shelter for Families.
- The Jobs for Homeless Consortium, a joint effort of three non-governmental agencies to provide employment and training assistance to the homeless.
- Homeplace Family Center, Travelers Aid Society of Alameda County, a drop-in center for homeless families with young children.
- Women's Refuge, a 30-day emergency shelter for women and children.
- Salvation Army Shelter, a 30-day emergency shelter for adults with children, and the Army's tutoring program for school-age children, A Room to Grow.

The purpose of these discussions and program surveys was fourfold: (1) to gain a general understanding of the size and scope of the problem of family homelessness in Oakland, (2) to outline the service delivery system in the city as it serves these families, (3) to describe innovative service programs, and (4) to identify issues and barriers preventing homeless families in Oakland from accessing the services they need.

Exhibit 1 is a table describing the interview participants for this site visit. Exhibit 2 is a flow diagram depicting the inter-relationships of the major components of the service system for homeless families in Oakland. Profiles of the programs visited are attached in the appendix.

III. Contextual Issues

As in cities and counties across the Nation, in Alameda County there is no single factor responsible for family homelessness. Rather, many factors appear to be working together to increase the risk that an individual or family will become homeless.

Approaches to addressing the problem of family homelessness are heavily influenced by the social, political, and economic environment. This next section describes the characteristics of the homeless family population, factors related to causes of family homelessness, when and how a response to the problem developed, and the political and social climate in Oakland.

A. Size and Characteristics of the Population

Like most of its urban counterparts in the United States, Alameda County has found that it can no longer characterize its homeless population as middle-aged, single, white, and male. Since the mid-1960s, the homeless population has swelled to include increasing numbers of women, children, African-Americans and Hispanics, people with drug-related or mental health problems, families, Vietnam veterans, and the recent and long-term unemployed.

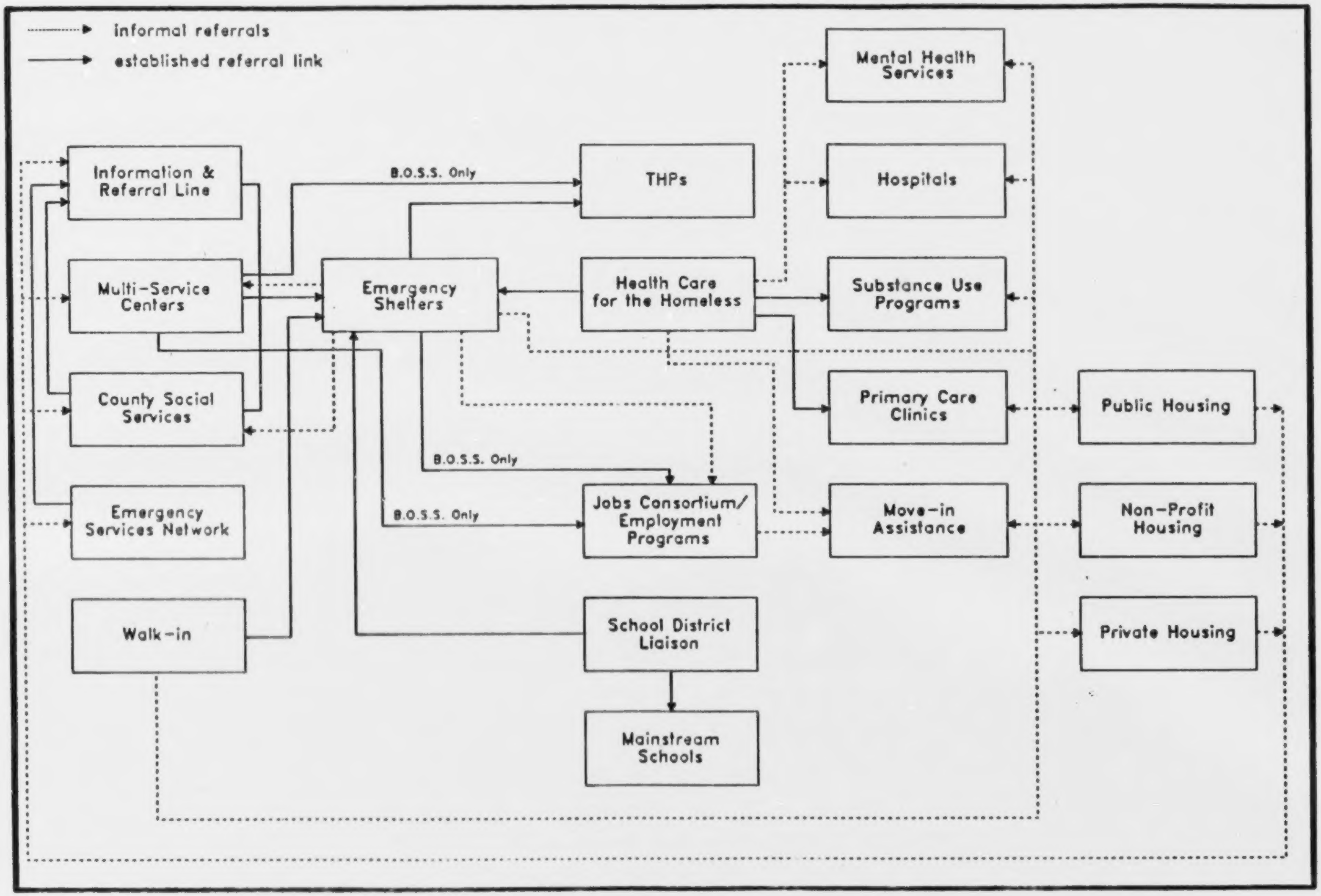
EXHIBIT 1

DESCRIPTION OF SITE VISIT PARTICIPANTS: OAKLAND

Program Name	Organization Type	Services	Toured Facility
Health Care for the Homeless	Health Program	Mobile and clinic primary care services for homeless individuals	
Women's Refuge	Shelter	Emergency shelter for homeless women and children	X
Salvation Army Shelter	Shelter	Emergency shelter for homeless families with children, educational programs for preschool and school age homeless children	X
Berkeley Oakland Support Services (BOSS)	Multi-Service	Emergency shelter, transitional housing services, employment and training, and social services for homeless individuals and families	X
Jobs for the Homeless Consortium	Employment Program	Consortium of three non-profit agencies providing training and employment services for homeless individuals and families	X
Emergency Services Network of Alameda County	Advocacy and Information	Coalition of representatives from the public, non-profit, and private sectors	
Homeplace Family Center	Drop-in Center	Support services for homeless families with young children	X
County Homeless Coordinator, Alameda County Administrator's Office	County Office	Oversight and coordination of county's efforts in homelessness	
Oakland Public Housing Authority	Public Agency	Oversight of public housing and Section 8 program	
Alameda County Social Services Agency	County Office	Funder of last resort for welfare and child protective services	

EXHIBIT 2

FLOW OF CLIENTS THROUGH THE SERVICE SYSTEM: OAKLAND


informal referrals
established referral link
Information & Referral Line
Multi-Service Centers
County Social Services
Emergency Services Network
Walk-in
B.O.S.S. Only
Emergency Shelters
THPs
Health Care for the Homeless
B.O.S.S. Only
B.O.S.S. Only
Jobs Consortium/ Employment Programs
School District Liaison
Mainstream Schools
Mental Health Services
Hospitals
Substance Use Programs
Primary Care Clinics
Move-in Assistance
Public Housing
Non-Profit Housing
Private Housing

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The Emergency Services Network of Alameda County (ESN), a coalition of homeless service providers and advocates, conducts an annual survey of the homeless population in Alameda County. ESN's 1990 survey indicates that during a one-week period in 1989, 2,419 different individuals received shelter in Alameda County. This figure represents an increase of more than 12 percent over the previous year.

In addition to raw numbers, the survey offers a composite profile of the homeless people served in Alameda County shelters. Three-fifths of the homeless served are from Oakland. The majority (59 percent) of county shelter residents are African-American; 30 percent are white. Nearly 30 percent are children under the age of 12.[2] The majority of adult shelter residents are women (58 percent)--29 percent are single women with children. Only 4 percent of those sheltered are intact families with children.[3]

The ESN survey also describes those homeless families and individuals receiving support services as well as shelter in Alameda County. The data reveal that homeless people receiving support services are more likely to include families with children and to have multiple problems. Of the 14,560 homeless individuals receiving shelter and services in 1989, 24 percent were children and another 24 percent were adults in families. Six percent were pregnant women. Fifty-five percent were either self- or staff-identified as abusing drugs or alcohol. These support service clients were twice as likely as non-support service clients to have been homeless for longer than one year. The data also indicate that 25 percent had no income upon entry to shelter. However, by departure, fewer than 10 percent lacked a source of income, because they had become enrolled in either AFDC or SSI.

Service providers and advocates recognize that this data is problematic. Because the homeless have no address they are difficult to count. In addition, the data are based on information from shelter and support service providers; therefore, it is impossible to assess the number of "invisible" homeless who may be doubled-up or tripled-up in tenuous housing situations or who have given up looking for shelter and/or are living in the streets. Finally, Oakland service providers believe that homeless families are overrepresented in shelter surveys because there are a disproportionate number of shelters serving families.

B. Factors Related to Family Homelessness

Economic or Structural Factors. Advocates and service providers identified several major economic or structural factors affecting family homelessness in the county. These factors include a lack of affordable housing, decreased job opportunities, and the inadequacy of public assistance programs. In addition, homeless services in Alameda County were impacted significantly by the October 1989 Loma Prieta earthquake.

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[2] Only 3 percent of shelter residents are between 13 and 17 years of age. This small number is due to the fact that most shelters will not serve boys over age 13, and children are often sent to live with friends or relatives while parents go to a shelter or live on the streets.

[3] Some of the providers interviewed in Alameda County indicated that in recent years they have served an increasing number of intact families or fathers with children.

Of all the above factors, the severe shortage of housing for individuals with low incomes is most serious. According to the ESN survey, 32 percent of all adult shelter residents are homeless as the result of an end to a temporary living situation; another 20 percent are evicted for inability to pay rent. In general, increases in home rental and home ownership costs, declining Federal subsidy of low-income housing, and the loss of urban housing stock due to redevelopment (particularly in downtown Oakland) are responsible for the low-income housing shortage. Alameda County housing and rental costs are high. Also, the housing vacancy rate in the county is significantly below the 5 percent rate generally considered a sign of balance between supply and demand. The waiting list for public housing is extremely long, with an average waiting time of 3 to 4 years.

The second factor, decreased job opportunities, is related to a nationwide economic trend. As the county experienced a shift from manufacturing to service-related jobs in the 1980s, many jobs were lost and those that were created were lower skilled and lower paying. Alameda County advocates believe that because of this, those individuals who were already living on the margin became more susceptible to becoming homeless.

The third factor, reductions in public assistance benefits in the early 1980s, affected most State governments. However, in California these benefits have been generally quite liberal. Recently though, both Oakland and Alameda County have been hard hit by budget deficits. Programs were cut and cost of living increases for entitlement programs frozen. Alameda County Social Services, the welfare and child protective services provider for Oakland, is often the provider of last resort for homeless and potentially homeless families. In the past fiscal year, both general assistance and AFDC levels failed to keep pace with the cost of living. At the same time, the size and intensity of the service demand increased greatly, further taxing the agency's ability to cope.

A final factor affecting Alameda County homelessness is the 1989 earthquake. Many families were left homeless when downtown Oakland single-room occupancy hotels (SROs), where homeless and at-risk families find temporary shelter, were severely damaged and ultimately destroyed. A total of 1,600 units were lost. On the other hand, the earthquake brought in a significant amount of new funds from the Red Cross, FEMA, and others. However, according to Oakland service providers, these funds have a major hitch; in many cases, they are tied to serving the new "earthquake homeless" and cannot be used to serve those who are homeless for other reasons.

Individual Factors. In the site visit discussions, informants mentioned a number of individual factors related to family homelessness. These include domestic violence, divorce or separation, running away from home, being released from jail or a hospital with nowhere to go, health-related problems, and natural disasters. According to the ESN data, somewhere between 12 and 37 percent of emergency shelter residents attribute their homelessness to domestic violence. Site visit informants report that drug and alcohol abuse has risen steadily over time in Oakland and also has become a major problem among the homeless people.

C. Development of a Response to the Problem of Homeless Families

Several aspects of the Alameda County service system have shaped Oakland's response to the problem of homelessness, and more recently, to the problem of homeless families with children. They are (1) the strong, early response from community-based organizations in the county, (2) the county's success with special project funding, (3) the existence of separate city and county political jurisdictions, and (4) the prominent role played by two large service providers, one public and one private, non-profit, who offer a network of services to homeless families.

Strong Community-Based Organization Response. In the early 1980s, when the homeless crisis began to emerge across the country, the shelter system in Oakland and Alameda County was made up of a variety of predominantly religious programs geared to the moral reform of homeless men. Between the early and mid-1980s, however, the shelter system banded into a broad network of 22 emergency shelters and over 40 meal sites and emergency food programs to serve a more diverse homeless population that included families, teenagers, domestic violence victims, individuals with health problems, and individuals with substance abuse problems. They united loosely under the umbrella of the ESN to provide planning, policy development, information, and advocacy on behalf of the homeless.

Together, these community-based organizations joined forces to impress the Alameda County Board of Supervisors with the magnitude of the homeless problem. In June 1986, the Board convened the broad-based Alameda County Task Force on Homelessness (representing over 80 organizations) to examine the nature and extent of the problem of homelessness and to make recommendations on how to respond to it. According to site visit informants, at that time the composition of the Board was receptive to social problems. In 1987, the Board presented its analysis of the problem and made a series of 18 recommendations to be carried out by the Board, municipal governments, and the private sector.

As of December 1990, 16 of the 18 recommendations had been carried out. The recommendations included initiatives in the areas of housing, emergency services, reduction of institutional service barriers, and resource development. One of the recommendations implemented was the hiring of a County Homeless Coordinator who reports directly to the county's chief administrative officer and is responsible for assisting with county homeless initiatives.

Success with Demonstration and Special Project Funding. From 1988 through 1990, Alameda County developed a number of broad, new initiatives to address the root social and economic causes of homelessness in the county. The efforts were funded largely through Federal and State demonstration grants and special project dollars.

The largest government-funded program for the homeless is the Alameda County Health Care for the Homeless Program, which is funded through McKinney Section 340 funds. Since 1988, it has operated as an interdisciplinary program with multiple subcontractors and both formal and informal linkages with over 60 health and social service programs to provide health care services to the homeless. For pregnant women who are substance abusers, the county operates the Perinatal Pilot Project which is funded through the Federal Office of Substance Abuse Prevention as well as the State of California. Finally, the City of Oakland was selected as one of nine projects across the Nation to receive Robert Wood Johnson Foundation and HUD funding for its Oakland Homeless Families Program. This pilot project is expected to couple permanent housing and support services for 190 homeless families.

The director of the Alameda County Health Care for the Homeless Program has pulled these various grant-funded initiatives together into a comprehensive package for at-risk pregnant women and homeless families with children. At the time of the site visit, the key service providers in the county were preparing for a visit from another potential funder, the Better Homes Foundation, which was considering the city for a grant to develop services for homeless pregnant women. Informants hoped these multiple funding efforts would result in a unified system of coordinated service delivery for a group of homeless families who would be served through a single intake process and, where possible, through shared resources.[4]

Separate City and County Political Jurisdictions. Oakland is encompassed by Alameda County. In providing social services, the city has taken a back seat in recent years, and has instead focused on redeveloping the downtown business area. Alameda County has taken primary responsibility for welfare and child protective services. Site visit informants reported that having separate political jurisdictions has, at times, added an extra layer of unnecessary bureaucracy to homeless service efforts. For example, they related the recent problems involving the development of a multi-service center for the homeless. Because the Red Cross awarded the county and city the money for the project, in order for the project to get underway, both the city and county needed to sign a joint venture agreement. While the two attempted to come to terms, the project stalled temporarily; in the meantime, nearby San Francisco's project was already underway.

Existence of Two Large Homeless Service Providers. The existence of two large homeless service providers, Berkeley Oakland Support Services (BOSS) and the Health Care for the Homeless Program has allowed the homeless families served by these programs to receive a greater range of services than is available in smaller programs. In the case of the county-administered Health Care for the Homeless Program, a variety of different county and community-based resources has been consolidated into a comprehensive package of services allowing participating families to receive primary health care, alcohol and other drug recovery services, and a wide range of support services. These services are coordinated by community health worker/case managers who provide the initial intake and assessment, make service referrals, and perform follow-up services.

BOSS, a 20-year-old, private, nonprofit organization, offers many different types of programs. It is the single largest provider of emergency services and assistance for Alameda

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[4] Since that time, the site visit team learned that the County received a grant from the Better Homes Foundation to fund services for pregnant, homeless women.

County's marginally housed and homeless. Services available for families include two multi-service centers, a family emergency shelter, transitional housing programs, a substance abuse program, a homeless employment program (the Jobs Consortium), as well as a variety of advocacy services. Tying these programs together is BOSS's family case management program which offers all families entering the BOSS program network in-depth assessment and counseling and access to resources.

Outside of these two programs there are a number of comprehensive service programs for homeless families; however, they are not able to provide families with access to a continuum of services the way that these two larger programs can.

D. Political and Social Climate

The current political and social climate for serving homeless families is mixed. Service providers in Oakland and the county are active, cooperative, and innovative. Most are optimistic about the possibility for creative solutions to the problem of homelessness and homeless families with children in particular. However, both the city and the county are facing major service cuts due to a $50 million city budget deficit and a county budget shortfall. Informants indicated that in the past fiscal year most service programs received budget cuts. It is expected that programs in the county that provide coordination rather than direct services, such as ESN and shelter intake and referral systems, will be hard hit by the budget axe.

Most site visit informants agreed that the county has been more responsive to the problem of homeless families than the city. However, even at the county level, the response depends largely on the character and composition of the Alameda County Board of Supervisors. At the time of the site visit, homeless services had recently been deleted from the Alameda County general fund budget. Many government, provider, and advocacy representatives fear that given the limited tax-raising ability of the city and county due to Proposition 13, the outlook for local-level funding for homeless services in the near future is poor.

IV. System Coordination Efforts

Oakland has a number of system coordination efforts. These efforts operate at the government agency, service provider, and individual family levels, increasing the likelihood of coordinated service delivery to homeless families with children. They are as follows:

A. Coordination Efforts at the Agency Level

The site visit team found few interagency funding or coordination efforts for the homeless at the public agency level. This is particularly true for the City of Oakland, which, according to site visit informants, has not played a lead role in the planning and coordination of services. Agencies at the county level vary in the degree to which they are involved in coordination activities.

A key example of county agency service coordination is the County Homeless Coordinator, who, since the late 1980s, has been responsible for helping to improve coordination among county-funded homeless services. The Homeless Coordinator's position is situated within the Office of the Alameda County Administrator, which has ultimate budget authority for county services. Non-profit service providers, particularly the Emergency Services Network, work closely with the Homeless Coordinator. Although some informants indicated that the Homeless Coordinator position has not been given the interagency planning and policy authority needed to have a major impact, the mere existence of the position demonstrates some county responsiveness to homeless issues.

Other county agency coordination activities fall within the framework of service delivery. The Health Care for the Homeless Program within the Alameda County Health Care Services Agency is active in service coordination. The program contracts with other public and non-profit agencies to provide services to the homeless and works closely with community-based homeless providers to ensure that services are provided efficiently and effectively. Finally, many of the county and city service agencies send representatives to the meetings of the Emergency Services Network, a coalition of predominantly non-profit service providers.

Still, the prevailing view among county agencies themselves is that the County Social Services Agency, Employment Development Department, city and county Housing Authorities, and the schools have not led coordination efforts, if they have been involved at all. The impetus for these activities stems from the non-profit provider community.

B. Coordination Efforts at the Provider Level

The general service philosophy among Alameda County service providers is that the homeless need to have some dedicated service programs in addition to the services provided in the mainstream service delivery system. This is especially true for health care and employment services. Providers believe that because the homeless are difficult to serve and mainstream services are limited, the homeless often are not served. On the other hand, many of the homeless service providers are quite innovative in working together, both to develop and deliver services.

Alameda County has several examples of homeless coordination vehicles. In addition to the County Homeless Coordinator described above, these vehicles include the Emergency Services Network and the various shelter information and referral networks.

ESN plays a key role in coordinating efforts among service providers. Originally a coalition of concerned service providers, ESN has expanded to include over 130 organizations including community-based organizations, city and county agencies, schools, churches, elected officials, and concerned individuals. ESN members meet on a monthly basis to address various issues related to homelessness, including homeless families with children.

In addition, ESN has taken the lead or worked with other key players in the service system on community-wide homeless activities and funding opportunities. Finally, the coalition's annual data collection activities for the county have assisted in the policy and planning debate on homelessness.

Two shelter information and referral systems were also mentioned as important collaborative vehicles. The East Oakland Switchboard and Eden Intake and Referral provide the homeless with information about shelter vacancies in the county. Although shelter participation in these efforts is voluntary, most choose to participate.

Service providers are collaborating on a number of specific service projects, including the Jobs Consortium, Oakland Homeless Families Program, and the multi-service center. Informants felt that the key to successful development of these efforts was not just the willingness of providers to work together but their willingness to share funding. In many instances, providers as a group have chosen the best positioned provider to go after certain funding opportunities rather than splitting up the funding into shares too small to be effective.

The Jobs Consortium, a program that helps homeless persons in Alameda County find employment, is an example of multiple programs working together at one site. Started in late 1988 under a Federal Department of Labor grant, the consortium pools the resources of three local agencies, the Center for Independent Living, Berkeley-Oakland Support Services, and the Oakland Private Industry Council. Services are geographically co-located and each agency provides its particular expertise: the Center for Independent Living provides counseling and job development services for disabled persons, BOSS provides the same for non-disabled persons and also provides support services including shelter and child care, and the Oakland Private Industry Council provides education and training.

Several other service projects link a variety of services and provide case management to homeless families to help them access the comprehensive package of program services available. As described above, the Alameda County Health Care for the Homeless Program and the Oakland Homeless Families Program focus on building a comprehensive service infrastructure for homeless individuals or families and use case managers to assist families through that system. The latter program will provide a range of services at two community service centers. Both projects have coordinated data collection and evaluation efforts between community-based organizations and the lead agency.

Finally, the city and county are now in the process of developing a large multi-service center in downtown Oakland with Red Cross emergency relief funds from the 1989 Loma Prieta earthquake. The multi-service center will provide drop-in and other basic support services to homeless individuals and families at one site. In conjunction with the multi-service center, Dignity House West and Travelers Aid are developing an 18-month transitional housing program which will serve approximately 150 people.

C. Coordination Efforts at the Family Level

The degree of service coordination a homeless family receives in Alameda County depends largely on where the family receives services. The larger programs such as BOSS and Health Care for the Homeless are better able to provide linkages with needed services either within their own programs, as in the case of BOSS, or with other programs, as in the case of Health Care for the Homeless. When the Oakland Homeless Families Program begins, participating families will receive ongoing case management services immediately following the initial intake and assessment to the program. These families will be served at the two community service centers and will receive support services coupled with access to permanent housing.

The majority of shelters in Alameda County provide a bare minimum of services. Many are not open during the day and most serve families for only a 30-day period. After this 30-day period, families are reported to either move into a house or apartment, to another shelter, or to an unknown site.[5] While some new programs have developed to meet families' needs during the day, such as Homeplace Family Center, most shelters, even those few providing comprehensive services, are not linked to longer-term housing or social support services. Follow-up services once a family leaves a shelter or a program are practically non-existent.

V. System Comprehensiveness

This section presents the service system components and describes how each addresses the needs of homeless families. Within each component is a description of the primary service providers or actors, how services are provided, their comprehensiveness, capacity, and barriers and gaps in service delivery. It should be noted that the following comments are general impressions based on interviews with a limited number of government agency representatives, service providers, and advocates.

A. Housing Continuum for Homeless Families

The following describes the various housing services available in Oakland and Alameda County for homeless families.

Emergency Shelter. Shelters in Alameda County serve a wide variety of special populations including women and children, intact families, single adults, victims of domestic violence, and the mentally disabled. In 1989, there were 23 shelters in the county, with approximately

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[5] In its 1989 count, ESN reports that after a shelter stay homeless individuals or families depart for the following: 32 percent for a house or apartment, 22 percent to another shelter, and 22 percent to an unknown site. The rest leave to stay with friends or relatives (9 percent), the street or a car (7 percent), an SRO (5 percent), or a residential drug treatment program (2 percent).

800 shelter beds.[6] These shelters receive funding from a variety of sources including the county; city; State; foundations; Federal funds through the Community Development Block Grant (CDBG), FEMA, and McKinney programs; and through program fundraising activities in the community. In addition, some mental health and drug and alcohol funding is available. Somewhere between 50 and 60 percent of all requests for shelter are from families with children.

Families can access the shelter system by calling shelters directly, or they can find out about shelter space availability by calling one of the two information and referral hotlines in the county. Most shelters in the county are small and are not open during the day. Families are often sheltered far away from downtown due to lack of space in the downtown Oakland shelters. When necessary, families may be vouchered into hotels or motels by the county Social Services Agency. If no vouchers are available, the family will not receive shelter at all.

Many shelter providers believe that although the percentage of long-term homeless is increasing in Oakland and Alameda County, families tend to not be among the long-term homeless (homeless one year or more). This data is difficult to gather with any certainty because many of the programs for families such as Health Care for the Homeless and BOSS serve multiple problem families rather than families in need of short-term shelter and no support services. For the homeless population in general, ESN reports that in 1989, 43 percent of the homeless were homeless for less than one month, 25 percent for 1 to 6 months, 15 percent for 7 to 12 months, and the remainder for either a longer or an unknown amount of time.

Site visit informants agree that there is a general shortage of emergency shelter openings in the county. Even with the number of emergency beds increasing every year, agencies and shelters are not able to keep up with the demand. One provider reported that in Oakland, the shelter system can serve only 30 families per night. ESN shelter data support this estimate. In 1989, 72 percent of all requests for shelter were denied; approximately three out of four due to lack of space. Another 10 percent of the denials are due to a shelter's inability to handle the special needs of a homeless person or family, such as a disability or drug or alcohol problem. According to service providers, very few shelters will admit an active substance user, and waits for drug treatment recovery beds average 6 to 8 weeks. The remaining 18 percent of the shelter denials are due to shelter program limitations, which include factors that may make a person ineligible for services such as being a teenage boy or an intact family. Many shelters do not accept either teenage boys or families with fathers.

The emergency shelter/housing system is widely considered the weak link in the service delivery system for homeless families. Because many shelters are small and not open during the day there is little access to non-shelter support services. In addition, 30-day shelter stays are considered too short to allow clients to stabilize their living situations. Nevertheless, it is recognized that shelters do serve an important role in assisting clients with their applications for public assistance or providing some time for clients to develop resources. According to data collected by ESN, the levels of both AFDC participation and successful job searches rise considerably after shelter stays.

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[6] This figure includes winter relief beds, which vary in number and availability.

Transitional Housing Programs (THP). Transitional housing is described by several site visit informants as badly needed. Most of the programs are small, serving 4 to 6 families. BOSS operates four transitional housing programs (two of which are for families) within its network of services for homeless individuals and families. Another small program is operated by the Women's Refuge emergency shelter and can serve up to 12 individuals in a four-family duplex. This program accepts families who have gone through the Women's Refuge emergency shelter or a similar 30-day shelter. Because there are so few transitional housing programs, few linkages exist between emergency shelters and transitional housing.

Permanent Housing. Homeless families in Oakland face a long wait for rent-assisted or public housing. In Oakland, the city Housing Authority manages 7,000 Section 8 housing certificates and 3,300 public housing units. The Housing Authority reports that it keeps one waiting list for both; as of December 1990, this waiting list was 28,000 persons long. For three bedroom units, the wait averages five years. Neither homeless individuals nor homeless families with children receive priority for public housing, and there is no link between participation in transitional housing and access to permanent housing.

The Oakland Housing Authority describes itself as a business that manages housing. The agency makes it a general practice to deal with housing and not social services issues. In somewhat of a departure from this policy, the Housing Authority will handle the management of 123 Section 8 certificates for participants in the new RWJ-funded Oakland Homeless Families Program. Before this program, the Housing Authority and the Alameda Health Care Services Agency had very little interaction.

Site visit informants identified several non-profit organizations who either assist in developing low-income housing or who help renovate substandard housing. These organizations, such as Traveller's Aid, Dignity West, Jubilee West, and Echo Housing, are also involved in assisting families with housing counseling, rental assistance, and placement.

Other Housing Assistance. The Alameda County Social Services Agency administers two housing assistance programs: one for AFDC-eligible homeless, and the other for non-eligible families and individuals. The former, the Homeless Assistance Program (HAP), is financed through AFDC funds, and as such, is a Federal/State/county financed program. In order to participate in HAP, clients must be homeless and AFDC-eligible. Once a year, families may apply to receive HAP funds to pay for up to three weeks of temporary shelter (up to $210 per week). Once permanent shelter is found, the program pays for the family's last month rent and security deposit.[7] Participants are prohibited from renting any unit exceeding 80 percent of their monthly AFDC benefit. For a family of three receiving $694 in AFDC benefits each month, finding an apartment that qualifies is a difficult task; a two-bedroom apartment in Oakland rents for an average of $800-900.[8]

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[7] In California, renters are often required to pay the first month rent, last month rent, and security deposit up-front.

The second program, Critical Family Needs Housing Assistance (CFNHA), is a county/private sector-funded program intended to provide housing assistance to those families who are not eligible for the AFDC Homeless Assistance Program. A key target population is working poor families. CFNHA operates as a one-time only service for individuals who have never received HAP funds. It offers first- and last-month rent and the security deposit. In contrast to HAP, CFHNA funds can be used to provide assistance to families who are in danger of becoming homeless.

Recently, CFHNA program funding has been cut significantly. For the 1991 fiscal year, county funding was reduced by more than half, while the private funding component increased only slightly. At the same time, the administrative funds used to pay community-based organizations to perform program intake were totally cut. Although CFNHA is considered a critical counterpart to HAP, funding for the program is usually exhausted each month before the month is half through.

B. Health and Developmental Services

The Alameda County Health Care for the Homeless Program is the main actor in the county on health care issues for the homeless, including child developmental services. Program services are provided in a variety of ways: by mobile van, on-site at shelters, and through contracted arrangements with mainstream health service providers. Site visit informants describe the program as one of the few government programs that is responsive to the needs of homeless families. As described earlier, Health Care for the Homeless has been particularly successful both in providing direct services and in coordinating existing resources into a comprehensive service package for homeless families.

Health Services. The Health Care for the Homeless Program provides primary care services, support services, and alcohol and drug treatment services to homeless individuals and families. The program directly provides health services out of a mobile van at 16 shelters, 2 city parks, and 2 alcohol and drug treatment centers on a regular basis. In addition, the program subcontracts primary care services with 10 community clinics and 1 county health center, and subcontracts drug treatment services with 2 alcohol and drug treatment centers. As part of the subcontract, these service providers agree to serve the homeless on a drop-in basis or close to the same day they are referred, rather than requiring them to wait the 4 to 6 weeks it often takes the general population to get an appointment. The subcontractors are paid on a fee-for-service basis.

Specific primary care services offered to pregnant women include prenatal care and referral to clinics for high-risk obstetrical patients. Children receive general health screenings, immunizations, and child growth and development assessments.

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[8] The HUD assessment of the Fair Market Rent for a two-bedroom is lower, $763.

Securing regular prenatal and early pediatric services is problematic for homeless women and children. Fewer and fewer private physicians accept Medi-Cal patients; public hospitals may turn pregnant women away; and community health centers and clinics serving low-income women often have long waits for appointments.

Developmental Services. Health Care for the Homeless offers homeless children developmental assessments through its mobile van and contracted primary care sites, and often refers children to mental health services. In addition, Health Care for the Homeless relies on California's statewide system of regional centers for developmental disabilities. These centers typically do not offer therapy or intervention services, but instead function as brokers of rehabilitative and developmental services, linking children with service providers in the community.

Health Care for the Homeless staff report that developmental services are a major gap for homeless children in the county. Unless children are drug-exposed, most are not eligible for services because they do not meet specific program disability criteria. Eligible children often face long waits for intervention services.

C. Education

The comprehensiveness of education services for homeless children varies based on the age of the child. Educational services for homeless school-age children are well-linked to the shelter system; for preschool-age children, service linkages are not yet established.

School-age. The City of Oakland buses children in emergency shelters to their school of choice within the district. Since July 1989, the Oakland Unified School District has employed a District Liaison to act as the intermediary between the public schools and the emergency shelters. The impetus for these actions came from Oakland shelter providers who found, not surprisingly, that school-age children were missing school and often tested significantly below their grade levels. The City of Oakland responded by passing legislation allowing children to be bused from shelters to their home schools. The District Liaison, whose position is funded through Federal Chapter I funds, currently works with seven different shelters that allow families.

Each day, the District Liaison communicates with the shelter providers to obtain a list of school-age children from the daily shelter intake. These children's names are investigated in the school system's "student locator" to determine if the children have received any special educational services in the past. Then, under the parent's guidance, the child is either placed in a school near the shelter (if space is available), bused to the child's home school, or bused to school at the site of the child's future residence. The district provides bus tokens for the child. If the child misses school, the District Liaison calls the shelter to check up on the child.

Both the District Liaison and shelter providers interviewed report that most school-age children are now attending school. Some shelter providers even commented that in order for a family to stay in their shelter, the family's school-age children must attend school. The only major barrier consistently identified is that bus tokens are not provided to allow parents to accompany younger, school-age children. Parents are often afraid to have their younger children bused across the city to school and may choose not to send them to school. A few shelters have taken it upon themselves to pay for bus tokens for parents who wish to accompany their children.

BOSS is taking a different approach to education. Staff feel that homeless children are often not well served by the mainstream public school system: they are often in shelters far from their schools, may switch shelters and schools frequently, and may experience significant social problems because of the stigma attached to being homeless. As a result, BOSS has hired a teacher from the Alameda public school system to teach children on-site at the family shelter. In addition, program staff are trying to get the school system to allow children to be taught at the shelter for a period of 3 to 6 months.

Preschool. Oakland has few services for homeless preschool-age children. Shelters report that the majority of children are not attending Head Start and no formal or informal links between the shelters and Head Start have been established. Informants attributed this gap to the general lack of social services available to low-income children. With many non-homeless children on the waiting list for Head Start, they consider it unlikely that homeless children, who are difficult to serve, will be given priority.

A few programs offer child enrichment programs for homeless preschoolers, however. Homeplace Family Center, a drop-in center for homeless families, has a Child Enrichment Program, with educational activities as well as a parenting component. The Salvation Army Shelter offers the Children's Activity program to shelter residents.

After-School. The study team identified a few informal programs that provide school-age children with after-school tutoring. One, A Room to Grow, is run by volunteers and offers children tutoring twice a week at the Salvation Army shelter. Tutoring programs are also offered at the Homeplace Family Center and in the BOSS Harrison House family shelter.

D. Child Care

Child care, particularly respite care, is a major gap among services for homeless families in Oakland. There are no publicly funded child care services targeted to homeless children. The two major sources of child care are State-subsidized, vouchered child care services for low-income children, and GAIN child care, for participants in the State's welfare reform initiative. Homeless children could be served in either of these programs, but, according to service providers, they are not. Low-income child care is in short supply and homeless mothers rarely participate in the more formal employment and training programs because these programs are unable to meet homeless families' multiple needs.

Because many homeless families stay in emergency shelters for a period of 30 days or less, and many shelters are not open during the day, what is needed most is respite care. This type of child care would allow parents to arrange for public assistance or look for employment during the day.

A few shelter programs such as BOSS, the Salvation Army, and Women's Refuge have informal child care or "babysitting" arrangements for shelter families. Other shelters do not allow children to be left unattended. Another type of program, family drop-in centers, has developed in recent years to help families during the day with their support service needs. Homeplace Family Center offers parents daytime, drop-in support services, including a child care/child enrichment program for preschoolers.

E. Other Support Services

The more comprehensive shelter programs and the transitional housing programs offer life skills training (including budgeting assistance), parenting education, counseling services, and help families build support networks. These programs include BOSS, Women's Refuge, and Homeplace Family Center. Many of these programs, including Health Care for the Homeless and the Oakland Homeless Families Program, also help families with their housing searches and may assist with move-in supplies. The Jobs Consortium offers support services in addition to its direct employment and training services.

F. Employment and Training

The mainstream employment and training system was described by informants as not being particularly helpful to the homeless. The Employment Development Department, which administers employment and training programs, has not been a key player in homeless services. Service providers indicated that Federally-funded programs such as the Job Training Partnership Act have so many restrictions and requirements that programs cannot properly meet the needs of homeless clients. Because of this, the Center for Independent Living, BOSS, and the Oakland Private Industry Council joined forces to create the Jobs Consortium, which is dedicated to the homeless. This program offers homeless people a wide variety of resources to meet their basic human needs, to improve self-esteem, and to develop elementary job skills.

G. Other Program Linkages

Child Welfare and Protective Services. Within Alameda County, homelessness is not considered evidence of *de facto* child abuse or neglect. It may, however, prevent a mother from getting children back who have been placed in foster care. One provider mentioned that fear of child protective services (CPS) may prevent women who are drug dependent from seeking services in the mainstream system. Otherwise, the concern appears on the opposite side--that CPS is unable to respond to child abuse and neglect problems among homeless families rather than being overzealous in removing children from the care of homeless parent(s). Shelter providers report that they make referrals to the Alameda County Social Services Agency's CPS on an as-needed basis. However, on occasion, shelter staff have found that it difficult to get CPS to respond adequately. Staff at the county Social

Services Agency agree that CPS staff are overwhelmed with high caseloads and may not be able to respond except in crisis situations.

Entitlement System. According to the Alameda County Social Services Agency, most homeless families with children are receiving AFDC benefits when they enter the shelter system. If not, they most likely had received benefits at one point and then became disconnected from the program. As the ESN survey demonstrates, the overwhelming majority of homeless families are receiving AFDC upon exit from shelters.

In addition to administering AFDC and General Assistance, the Social Services Agency administers the AFDC Homeless Assistance Program, which was described earlier. According to social services staff, this program has been popular but very open to abuse because, in the past, homeless families have not had to justify how they spent the money. Since January 1991, families have been required to verify their shelter address before receiving the homeless assistance funds.

Substance Abuse Service System. Alcohol and drug abuse problems are sometimes the cause and sometimes the effect of homelessness. In Oakland, according to ESN data, the percentage of shelter residents with drug and alcohol problems has increased dramatically over the past five years. Women of childbearing age are believed to be the fastest growing subgroup among the alcohol and drug using population. Services, particularly residential treatment services, for the general homeless population and especially for pregnant women are a major gap in the county.

Referrals of homeless individuals or families to substance abuse services occurs largely through the Health Care for the Homeless Program or directly to treatment programs. Health Care for the Homeless contracts with two alcohol and drug recovery programs for priority service. As a new target population, pregnant and parenting substance users will be the focus of one piece of the Oakland Homeless Families Program. Currently, these women can receive services at Mandela House, which has 6 residential beds, and Orchid Women's Recovery Center, which has 12 beds. To address the lack of drug treatment services, the Perinatal Pilot Project contracted with Healthy Babies, a community-based organization, to establish and operate one non-residential treatment center with the capacity to serve up to 40 women and two residential treatment facilities with a total of 30 beds. These new facilities will be made available to those homeless pregnant and parenting women participating in the Oakland Homeless Families Program.

Domestic Violence Service System. Although the site visit team did not visit any programs specifically for battered women, shelter providers spoke of this population as having critical needs that intersect with the emergency shelter system. One homeless advocate believed that domestic violence is increasing in Alameda County, particularly as recession sets in, jobs become more scarce, and family stress levels increase. According to shelter providers, the domestic violence shelters tend to fill up fast; consequently, shelters are used as a second resort. For Women's Refuge, which is operated in an undisclosed site, this does not pose a problem; however, most shelters are unable to offer women the protection from abuse they may need.

VI. General Issues and Barriers Related to Service Comprehensiveness

Oakland's response to the problem of family homelessness has some identified strengths as well as service gaps and other barriers to a comprehensive and coordinated service system. Following is a summary of the major strengths and barriers that were consistently mentioned among several of the site visit informants and observed by the site visit team.

A. Strengths and Innovative Efforts

The main feature distinguishing Alameda County's service delivery efforts for the homeless is its strong provider community. Advocates and service providers have served as the main force behind the community's response to the problem. By banding together to form the ESN, providers and,later,others impressed the Alameda County Board of Supervisors with the need to address the problem of homelessness. Eighteen service recommendations were made; sixteen were carried out, including the creation of a county-level homeless coordinator.

The mainstream service delivery system is not viewed as a major strength. Instead, individual service providers have become experts at working around the service system and bringing in outside funding to create additional services where gaps exist. Two large programs exemplify this method of operation: the Alameda County Health Care for the Homeless Program and BOSS. Health Care for the Homeless, which is county administered, has a direct link to the Alameda County Health Care Services Agency director. According to program staff, this close tie has given the program more leverage and flexibility than most county programs. The director of Health Care for the Homeless has tied a number of different Federal and foundation grants together to provide a wide array of services to homeless families, including those with severe alcohol and drug problems and chronic mental health problems. BOSS also pulls in funding from a number of sources, but rather than improving and linking mainstream services, BOSS has developed its own comprehensive set of programs over the 20 years it has been in existence. With centralized family case management for the homeless families it serves, BOSS's goal is to provide a continuum within its own service programs.

B. System Gaps and Barriers

Housing. A major gap in the Alameda County service delivery system is the shortage of housing, from shelters to transitional to permanent housing. Site visit informants indicated that transitional housing and permanent housing were the most critically needed. The problem with shelters is not that they do not exist, but that they do not offer homeless families enough shelter or support to get their lives out of crisis. Some providers have responded to this problem by opening day-time drop-in centers for families that offer families a variety of educational, child development, and employment assistance. However, some key players in the service system see this trend as a negative one, because it is encouraging the duplication of services. In general, the housing continuum was described as far from a continuum. Shelter stays are often short and inadequate. The majority of shelters are not linked to transitional housing. And, because the waiting list for Section 8 certificates and other public housing is so long, permanent housing is not linked to either the shelter system or transitional housing.

Lack of an agency response. Another major gap in the system is the lack of an active response on the part of government agencies with a responsibility for homeless services. Except for the Alameda County Health Care Services Agency, the city and county housing, social service, employment, and education agencies are interested, but generally not involved, in responding to the problem in any innovative way. With the advent of the 2-year pilot Oakland Homeless Families Program, the city Housing Authority will play a greater role in the county's homeless service efforts. However, at this point, this does not appear to be a change in its traditional "housing only" philosophy.

Mainstream social services for children are not well funded. Site visit informants described the social service system in the county as not well funded. There is a serious lack of low-income child care, particularly respite care, and inadequate access to Head Start and child development services. As a result, shelters are providing child care on an informal (and perhaps illegal) basis, and day-time drop-in centers are being set up to meet the support needs of families with children.

Populations falling through the cracks. Shelter providers and advocates described certain special populations that are particularly likely to fall through the cracks in the service delivery system. They are large families who cannot find shelters capable of housing them; teenage boys who often are not eligible to be sheltered; pregnant teenage girls who may not be "technically" eligible for shelter; and families with special needs such as those with disabilities or active substance abuse. In addition, while several of the programs visited reported that they served intact families, they also reported that they are in the minority; very few other programs serve intact families. In general, those families that are most difficult to serve are the least likely to be served.

Case management occurs on a program-by-program basis. The site visit team chose to visit those housing/service programs that offered comprehensive services. In general, these programs are the exception. However, even these more comprehensive programs are only able to provide case management, life skills, parenting, counseling, etc., to clients while they are in shelter. In the case of 30-day shelters, this is a short amount of time. As discussed above, only the larger programs are able to provide any kind of continuity of care over time. Lastly, follow-up services were generally unavailable. Except for the Oakland Homeless Families Program, no programs were identified that had links to permanent housing. Once clients leave, programs have essentially no contact with them unless they become homeless again.

Funding. Funding was a major issue among those service providers and advocates interviewed. Both the county and city are facing budget crises that are likely to affect non-direct service activities such as the ESN and the shelter emergency and referral systems. The overriding complaint about program funding was that existing funding streams do not allow local communities the flexibility to address their particular needs. Programs have either categorical or short-term funding. The first creates bureaucracies and fiefdoms and the latter requires programs to be constantly writing new grants, taking away from time actually delivering services. In general, programs were in desperate need of longer term, stable funding sources.

Both the Alameda County Social Services Agency and the Oakland Housing Authority attributed the inability of local agencies to respond in a creative way to how their agencies are funded. Because the agencies are strapped for funding, have rising caseloads on a day-to-day basis, and must meet their regulations, they find it difficult to be forward thinking or plan for future problems. Agency staff believe that if their agencies are to step outside their current mandate to perform coordination activities or case management, these activities will have to be explicitly stated as the responsibility of each agency and funded as such. Otherwise, these activities will never be a priority.

Program Profiles

Oakland, California

Homeplace Family Center

Organizational Issues

Homeplace Family Center is a program of the Travelers Aid Society of Alameda County. It provides a "home-like" environment to homeless families with children during daytime hours. The program facility is located in the First Unitarian Church in downtown Oakland where families are served on a drop-in basis.

The program originated in 1987 in response to the problem of families being served in shelters that required them to leave during the day. Travelers Aid explored the possibility of networking with other homeless service providers and joined with the current director of the program, who coincidentally was looking to set up a similar drop-in program for homeless children. The original plan for Homeplace was simply to have the center serve as a place for families with young children to "hang out" during the day. Later, staff recognized the importance of providing support services as well. After a year of seeking funding, the program opened in 1990.

Homeplace currently serves approximately 10 families per day. According to program staff, the average family served is three-person, including two children. About 85 percent are African American; 80 to 90 percent are Oakland residents; and 20 percent are two-parent families.

Points of Entry

Homeless families learn about Homeplace through the program's street and agency outreach efforts, regular networking with other agencies, and through word-of-mouth among the homeless on the streets and in shelters. Recently, Homeplace held an open house to publicize the center and received a significant amount of media coverage.

Services are available during the week from Tuesday through Friday between the hours of 9 a.m. and 5 p.m. Staff report that they serve any homeless family that meets their one criterion--that the family have a child who is age 12 or younger. Aside from that restriction, so far, the program has not had to turn anyone away. However, as the program becomes better known, staff anticipate having to address this problem.

Service Delivery

Homeplace offers a diverse set of services including the following:

- Crisis intervention, which includes arranging a limited number of shelter vouchers for families that are unable to find shelter openings. (Homeplace receives funds from FEMA to finance vouchers for evening shelter. In addition, the center provides bus tokens to and from shelters.)

- Child Enrichment Program which is set up for preschool-age children but also has a parenting component.

- Long-term counseling for adults.

- Other services for adults--such as meals, training on empowerment and building support networks, a newsletter, adult education, and skill building workshops.

- A drug and alcohol recovery program which is not yet operational.

In addition to these direct services, Homeplace has arranged to have services provided on-site by other service providers and refers families to services off-site. These include:

- Health services which are provided twice monthly by the Health Care for the Homeless mobile van. In addition, Homeplace makes referrals when necessary to Children's Hospital and the Child Health and Disability Prevention Program.

- Employment referrals are made to the Jobs Consortium.

- Referrals to sources of food are made to many different food programs such as St. Mary's Community Center and Jubilee West, Inc. However, these sources are usually in short supply.

- Drug treatment referrals are made through Health Care for the Homeless or directly to a number of Oakland programs.

- Advocacy services are provided to assist families with any problems with child protective services, public assistance benefits, and landlords.

Coordination and Effectiveness of Services

The intake procedure for the program is relatively informal. Ideally, when a family enters the program facility, a staff caseworker will talk to the family about its problems. If the caseworker determines that the family has no immediate, pressing needs, an intake may not be performed at this point. However, if the family continues to come to the center, staff caseworkers will conduct a more formal intake that serves both to determine the services the family needs and to document program participation.

Homeplace finds that families vary in the extent of services needed. One-third of the families served by Homeplace are in immediate crisis, receive crisis services, and are not served again; one-third have essentially housing needs and the program may work with them for about 1 to 2 months; and a final third has multiple service needs and is served for 2 or more months.

Only process outcomes are measured. In the program's one year of operation it has served 200 families. On average, 10 families per day were served.

Financial Issues

Funding for Homeplace comes from many different sources. The largest source of funding is private foundations. The program receives a much smaller amount of funding from the Community Development Block Grant and the Mayor's Earthquake Fund. The total annual operating budget is $180,000. Because fundraising has not equalled the cost of operating the program, the program has had to cut staff positions.

Staffing

Staff includes a program director, assistant program director, two .5 FTE caseworkers who assist the families and children, and 1.5 FTEs on-site from BOSS (funded through the FEMA earthquake funds). The program is in the process of adding another .5 FTE from Travelers Aid to work with children and a .75 FTE for the Alcohol and Drug Recovery Program. The Oakland Homeless Families Program is expected to add an additional caseworker on-site for a six-month period.

Barriers and Issues Identified

Homeplace faces a constant struggle for ongoing funding. The program has already cut staff to meet program operating costs; its longer term funding situation is described as precarious.

The program has found the lack of transitional housing in Oakland to be a major problem for homeless families. Staff would like to be able to link their program with a transitional housing program so they could serve families for a longer period of time and with more stability than is currently possible with families in short-term emergency shelters.

Oakland families are often housed in shelters a great distance from downtown Oakland and Homeplace. This geographical separation makes it difficult for the program to provide ongoing support services.

According to program staff, child care, particularly respite child care, is scarce in the county. Homeplace has no link to Head Start. Because so few Head Start slots are available, program staff have not attempted to link the children with the program.

Women's Refuge

Organizational Issues

Women's Refuge is a 30-day emergency shelter for homeless women with children in Oakland that can shelter up to 25 individuals, including children. The program was first created in the early 1970s under the auspices of the YWCA as a battered women's shelter; for the past 8 years it has operated independently and serves women from a variety of circumstances. Recently, the program opened a transitional housing program in a renovated, two-story duplex that now serves up to 12 individuals.

The average woman served by the shelter is homeless due to eviction, in her late twenties, and has three preteenage children. A few of the women in the shelter are currently trying to regain custody of children who have been placed in foster care. Because shelter stays are restricted to 30 days, the program goals are limited. Women's Refuge expects to help clients become financially stable, but does not expect to get them into transitional or permanent housing.

Points of Entry

The program has several eligibility criteria. Participants must be at least 18 years old, homeless, self-identified community residents, and either have children or be pregnant. The program does not accept active drug users, men, or boys over age 12.

Women are referred to the shelter from other shelters, doctors, mental health professionals, or through word-of-mouth. No walk-ins are accepted. The initial intake for the program is by phone. If program staff determine that a woman meets program criteria she is then directed to a point one block away from the shelter. After staff determine that the woman is alone or with her children, she is directed to the shelter.

Service Delivery

Services offered by Women's Refuge staff include shelter, case planning, counseling, budget management, and meals. Services for children are more limited. School-age children either attend school down the street from the shelter or are bused to their home school by the city of Oakland. Preschool-age children are generally not in Head Start or any other preschool program.

The shelter stay is limited to 30 days. After this 30-day period families must leave; some go to other shelters, others to temporary living situations.

In addition to the services described above, Women's Refuge offers other services on-site and referrals to off-site services. Once a month the Health Care for the Homeless van provides health care services at the shelter. Also on-site, the Berkeley Office of Education within the Public Health Department offers an AIDS awareness workshop twice monthly, and the Berkeley Community Law Center also offers a workshop twice monthly. Referrals for special health care needs are made to the Berkeley Health Department, Children's Hospital, Alta Bates Hospital, Highland Hospital, and West Oakland Health Center.

In October 1990, Women's Refuge opened a transitional housing program for a small number of women and their children. Women are eligible to participate in the program if they have successfully completed a 30-day stay at Women's Refuge or a similar shelter. Four families are housed in the one duplex. While living at the house, families are assisted in getting into permanent housing and participate in support groups that offer assistance with goal setting, relationships, housekeeping, budgeting, and family planning. Transitional housing program participants can spend up to 6 months in the program.

Coordination and Effectiveness of Services

Upon arrival at the shelter, there is an initial intake process. Each woman is asked about her service needs, told about shelter rules, and must agree to a service contract. At this time, the process for accessing financial assistance is started and women begin to actively look for housing. Case planning includes assistance and referrals for housing, job search, and financial assistance. Information on outcomes was not available.

Financial Issues

The annual budget for the shelter totals $200,000. Most of their funding comes from Alameda County (54 percent) and the cities of Oakland (21 percent) and Berkeley (13 percent). About 12 percent comes from fundraising. The shelter contracts with the City of Oakland for six emergency shelter beds per night, with Berkeley for four beds, and with Alameda County for eight beds. The new Transitional Housing Program is funded through Federal McKinney dollars.

Staffing

The shelter has three full-time positions plus a few part-time positions. These include one director, one family living skills coordinator, two .5 FTE intake specialists, one live-in advocate who stays overnight at the shelter, one temporary staff person who relieves the overnight advocate, one part-time therapist who facilitates counseling sessions, and one contracted bookkeeper.

Barriers and Issues Identified

The major focus of the program is the female parent; children's needs are not consistently addressed. Women's Refuge staff indicated that they would like to link the children, particularly preschool-age children, to educational and developmental activities during the day.

Program staff feel that 30 days is insufficient time to adequately address the needs of the shelter residents. This is the main reason Women's Refuge opened the transitional housing program.

Salvation Army Shelter

Organizational Issues

The Salvation Army Shelter is a 30-day emergency shelter for homeless adults with children that also offers food, clothing, and other support services to nonshelter residents. The facility is located in the midst of welfare motels and SROs in downtown Oakland. The shelter has the capacity to provide emergency shelter to a total of 43 individuals per day (25 to 27 of whom are children); it also serves meals to 500 people per day. The shelter regularly operates at maximum capacity and as a result often has to turn families away.

The Salvation Army has developed several programs for homeless children. It offers an educational program for preschoolers, called the Children's Activity Program, and an after-school tutoring program for school-age children, called "A Room to Grow." In addition to these programs, the Salvation Army staff played a key role in helping to pass a district law allowing children to receive bus transportation to their home schools.

Points of Entry

The shelter serves only single parents with children and intact families. It will accept adolescent boys who are part of a family. In order for the family to stay in the shelter, the children must be in school.

Families learn of shelter space availability either by calling the shelter directly or through one of the two local, informal information and referral programs. Access to the Children's Activity Program is through shelter residency. A Room to Grow is open to Salvation Army shelter residents and, because transportation has recently been made available, to homeless children from other shelters.

The program hours for the Children's Activity Program are 1:00 p.m. to 8:00 p.m. in winter and 9:00 a.m. to 5:00 p.m. in summer. A Room to Grow tutoring is offered from 3:30 p.m. to 5:30 p.m., two days per week.

Service Delivery

In addition to providing evening shelter, the Salvation Army provides food, referrals to needed services, and assistance with accessing public assistance. Twice each week, the Health Care for the Homeless van provides health services on-site. The shelter requests that parents leave the shelter between 9:30 and 11:45 a.m. and 1:00 and 4:00 p.m. each day.

During the day, the shelter operates the Children's Activity program for preschool-age children. Infants and toddlers are given baths and naps. Older children participate in various program activities including arts and crafts, field trips, some educational instruction, summer-time visits to local parks, and day camp daily during the summer. The Children's Activity program operates as a cooperative; shelter parents assist program staff on a rotating basis.

School-age children are required to attend school. The shelter supplies bus tokens for children's transportation to school and will pay for parents to accompany their children to school, if desired. Since July 1990, the Salvation Army has provided after-school tutoring to school-age children at the shelter two afternoons per week. The program, A Room to Grow, offers children assistance with homework and reading. Children have access to some computer equipment and basic school supplies. The program is staffed entirely by volunteers. One day each week the Girl Scouts assist the children with a craft, and on Thursday nights Dominos donates pizza to the children.

The shelter has a duration of 30 days; the children's programs coincide with the shelter duration.

Coordination and Effectiveness of Services

The social worker and the children's activity director work together to provide case management. There is very little, if any, followup since parents seldom give forwarding addresses.

Effectiveness is measured only in process terms. Anecdotal information about the success of the children's programs has been very positive; staff have seen major changes in children's self-esteem and learning.

Financial Issues

The annual program budget for the Salvation Army's homeless activities is about $500,000. Funding sources include the Salvation Army, private donations, United Way, and some city and county funds (county funding is the greater of the two).

Staffing

The Children's Activity Program is staffed by the director and assistant director, with assistance from the mothers participating on a cooperative basis. A Room to Grow is staffed by two to three volunteer teachers as well as other volunteer groups from the community.

Barriers and Issues Identified

Shelter staff feel that their children's programs are very important. By providing children's activities during the day, parents are able to go out and look for employment and otherwise help stabilize their lives. The afternoon programs offer parents some peace and quiet which is often rare since families are usually housed together in one room.

Program staff indicated that there are few good programs available for homeless teenagers, particular adolescent boys. Although the Salvation Army Shelter takes young men up to age 18 years old, many programs do not.

Berkeley Oakland Support Services (BOSS)

Organizational Issues

Berkeley Oakland Support Services is the largest, nongovernment provider of emergency shelter and support services for Alameda County's marginally housed and homeless. The program originated in 1971 as the Berkeley Streetwork Project, in response to the large numbers of newly deinstitutionalized homeless. Since that time, it has adapted to meet the growing and changing needs of the homeless population, becoming Berkeley Oakland Support Services or BOSS in 1986. Today, BOSS provides a network of services for homeless individuals and families including emergency shelter, transitional housing, public benefits and housing advocacy, employment and substance abuse counseling, money management, health care and food referrals, and legal assistance.

In its nearly 20 years of providing homeless services, BOSS has come to recognize that when homeless services are provided in a coordinated and comprehensive fashion, the homeless are more likely to escape the stubborn cycle of homelessness and poverty. Consequently, a major objective of BOSS is to provide a continuum of services that addresses these issues. BOSS currently operates its multiple services in 10 sites and serves a large, diverse clientele, which in 1989 included 4,500 differentiated adults. Forty percent of all BOSS clients have at least one child and the majority of clients are Oakland residents.

BOSS programs operate under the philosophy that in order to be helped, the homeless must have a will to be helped. As a result, the services provided in BOSS programs are very interdependent, requiring families to set goals for themselves and to meet them.

Points of Entry

Homeless individuals and families learn about BOSS largely through word-of-mouth. Since the program has been around for so long it is fairly well-known. Other likely sources of referral to the program include other homeless service providers, media events, and networking activities.

A homeless family from Oakland is most likely to enter BOSS's network of programs through the Berkeley Multi-Service Center and its two sites in Oakland. At these sites, homeless people can receive nonresidential support services such as benefits advocacy, crisis counseling, mail services, and the use of a telephone.

BOSS does not turn away anyone from services. When it cannot provide shelter due to lack of space, BOSS attempts to link families up with some other emergency shelter option such as hotels or motels.

Service Delivery

BOSS operates many programs for homeless individuals and families including the following:

- Three emergency shelters, including one, Harrison House, which serves families for up to 3 months.
- Four transitional housing programs, two of which are for families and allow them to stay for 3 months to 1 year.
- Two multi-service centers.
- Housing advocacy, which assists clients with locating and securing permanent housing.
- Paralegal assistance for clients who cannot afford legal assistance.
- A substance abuse program that identifies, counsels, and refers clients to drug treatment programs.
- Family case management, which offers all families entering the BOSS program network in-depth assessment and counseling as well as extensive resources.
- Adult education that offers reading, math, independent living skills, and tutoring.
- A homeless employment program called the Jobs Consortium.

The study team visited three of these programs, the Berkeley Multi-Service Center, the Harrison House Emergency Shelter, and the Jobs Consortium. The following describes services for families at the Multi-Service Center and Harrison House. The Jobs Consortium is described separately.

As described above, most Oakland families enter the BOSS program network at the Berkeley Multi-Service Center. At this center, the family's immediate needs are addressed. These needs may be shelter, food, eviction prevention assistance, or help with a job search. Often families have more extensive needs. If BOSS believes a family would benefit from one of its programs, an extensive intake is conducted, linking the family to BOSS's family case management services.

Regardless of the service the family receives, the case management follows the family. If, for example, a family is sheltered at Harrison House--which serves 14 families for up to 3 months--the family is assigned a case manager. The case manager fills out a profile on the family, conducts a regular intake, performs an assessment of both the parent's and the child's needs, and works with the family to set up its goals and objectives. These goals and objectives are reviewed during weekly meetings. Also at these meetings, the case manager verifies that the family is linked up to needed income assistance and other support services. Another task the case manager carries out is helping the family develop a realistic budget. Before the family leaves the shelter, the case manager prepares the family for exit from shelter. If Harrison House is full, BOSS will offer families vouchers to hotels or motels and will provide these families with case management services as well.

BOSS links families to its own network of programs and to outside programs. For example, on-site at Harrison House is a family learning center that offers tutoring to adults and children. If the family has a substance abuse problem, it is referred to the BOSS substance abuse program, and if necessary, to Health Care for the Homeless and other drug treatment programs. For job search assistance, families are referred to BOSS' Jobs Consortium. While families receive shelter at Harrison House, children are required to be at school and to have their immunizations up-to-date. Families access health care services through Health Care for the Homeless which provides a mobile van on-site at Harrison House once a week.

BOSS services are of longer duration than most county services for the homeless. Families may remain in emergency shelter for 3 months and in transitional housing for 3 months to 1 year. Staff expect it to take families at least 8 months to move from homelessness into jobs and/or permanent housing.

In addition to these services, BOSS will play a key role in the new Oakland Homeless Families Program. Its main role will be to administer one of the two neighborhood service centers and to contribute case management services.

Coordination and Effectiveness of Services

All BOSS services come with a case management agreement that includes goal setting and weekly or monthly followup meetings. BOSS currently has three family case managers, two of whom are formerly homeless.

Effectiveness is tracked in both process and outcome terms, although process evaluation predominates. Extensive intake and tracking forms are used to ensure that families are linked with the services they need. The Jobs Consortium utilizes outcome measures, such as whether or not an individual is placed in employment, at what pay, and for how long.

Financial Issues

In 1989, BOSS program operating costs totaled $2.6 million. The BOSS network of programs has 42 different funding sources including Alameda County, Federal funds, United Way, City of Berkeley, State of California, foundations, and corporations. In addition, some program revenues come from shelter and transitional housing program fees, which are charged depending on the individual's ability to pay--40 percent of clients are able to pay.

Staffing

BOSS has 70 FTE staff, only 7 of whom are involved in program administration activities which include program development, fund raising, public speaking, and other publicity efforts. BOSS tries to ensure that a large percentage of the staff are formerly homeless; currently 50 percent of the staff have a history of homelessness. Two of the program clients are on BOSS's board of directors. BOSS employs three staff to serve as family case managers.

Barriers and Issues Identified

BOSS has 3 case managers for families; the program feels that in order to adequately serve families, 8 are needed.

In general, families remain at the Harrison Shelter for several months; unlike most other programs in the county, BOSS is able to shelter families for longer than 30 days due to the program's diverse funding base.

BOSS provides hotel or motel vouchers to families that it is unable to shelter; the program would rather use these funds to provide families with first and last months' rent.

Staff feel that many parents lack adequate parenting skills; many parents use physical punishment and have very little nonstressful interaction with children. As a result the program is placing more emphasis on its parenting education and child development activities.

Education and literacy among homeless children are major problems. Most children in the BOSS network of programs test 6 months to a year behind their grade level. BOSS is currently considering working with the school district to have homeless children educated on-site for 3- to 6-month periods.

The Jobs for Homeless Consortium

Organizational Issues

The Jobs for the Homeless Consortium, or Jobs Consortium as it is better known, is a joint project of three, nongovernmental, Alameda County agencies -- the Center on Independent Living, Berkeley Oakland Support Services (BOSS), and the Oakland Private Industry Council. The program began in late 1988 under a McKinney Job Training Homeless Demonstration Program grant from the Federal Department of Labor to address the employment needs of the homeless at one integrated service site.

The structure of the consortium allows for a mix of counseling, job development, training, and support services to be offered. The Center for Independent Living provides counseling and job development services for disabled persons; BOSS offers the same services to nondisabled persons and provides support services such as shelter for consortium clients; and the Oakland Private Industry Council provides education and employment training. Administratively, the Jobs Consortium coordinator reports to the executive directors of each of the three participating agencies.

The service philosophy of the Jobs Consortium is based on the recognition that the homeless face many barriers to employment and that job-hunting is often a full-time activity. The homeless face external barriers to employment such as lack of shelter, food, mailing address, phone, appropriate clothing, transportation, identification fees or union dues, driver's license, and personal hygiene items. Also, the homeless face internal barriers such as the lack of job search skills, interviewing skills, resumes, self-esteem, and possibly drug addiction. The Jobs Consortium operates under the belief that while the homeless have widely differing needs, they are best served by a combination of services within in a service continuum that address both the external and internal barriers surrounding homelessness and unemployment.

Points of Entry

Most Jobs Consortium staff are located in one office in Berkeley, where employment services, such as client-counselor meetings and job preparation workshops take place. Shelter services and some support services are located off-site.

Clients learn about the Jobs Consortium in a variety of ways. The program conducts some outreach at emergency and mental health shelters and on the street. After the 1989 earthquake staff performed outreach at the Red Cross relief site. In the past, the program has sent mailings to social service providers. These providers refer clients to the program on a regular basis.

The initial intake to the program is usually at BOSS shelters and multi-service centers. The program accepts all interested applicants unless there is evidence of active drug use.

Service Delivery

The Jobs Consortium service delivery continuum includes:

- intake
- individual counseling
- job counseling and assessment
- post-workshop counseling
- job search assistance
- training counseling
- support groups
- job placement
- post-placement support and followup

Within this continuum of services, the Jobs Consortium offers clients assistance with basic needs such as shelter, food, and clothing; additional material support such as lunch, bus tokens, and tuition; and transitional services to assist individuals with job retention, such as assistance in finding permanent housing. BOSS is the first option for shelter; if BOSS has no vacancies, the Jobs Consortium tries to link clients to other shelters.

The Jobs Consortium has made the identification and treatment of substance abuse a focus; the program employs a substance abuse counselor to handle ongoing substance abuse problems. Individuals with literacy problems are referred to the BOSS network of programs. BOSS is also responsible for providing child care services for many Jobs Consortium clients.

Coordination and Effectiveness of Services

The three participating organizations provide complementary services that are both coordinated and consolidated within one program.

In 1990, the program served 1,223 homeless persons. This same number received training for an average length of 53 days. Of the 1,223 served, 344 were placed in jobs, with an average hourly wage of $6.81. Outcome data show that approximately 30 percent are still employed after 13 weeks.

Financial Issues

The program is funded through the Employment and Training Administration of the Federal Department of Labor through a demonstration grant. Grants are awarded one year at a time. The Jobs Consortium is now into its third year. First year funding amounted to approximately $450,000; second year $600,000; and the six-month extension, $250,000. The demonstration requires a local match involving both funds and in-kind services; in Alameda County, this match is provided by private foundations and by BOSS, the Center for Independent Living, and the Oakland Private Industry Council.

Staffing

The program has a total of 14 FTE staff. The staff positions include a program coordinator, workshop coordinator, training coordinator, coordinator of BOSS staff, 5 employment counselors/job developers, 1 drug and alcohol counselor, 1 client assistance worker, and 3 clerical/administrative staff.

Barriers and Issues Identified

Program staff have found that the key to their success in employing homeless individuals is that they address both the external and the internal barriers to employment.

Traditional employment and training programs are not able to serve the homeless well because they are not able to address the wide range of needs that the homeless have, and have stringent regulations including, among others, residency requirements, proof of AFDC eligibility, and complicated forms.

Providing links or case management to existing mainstream services is considered important, however, advocates feel that homeless clients cannot be expected to travel all over the city tracking down services and still have the time and energy to find a job. Program staff believe that more consortiums need to be created that rely on existing expertise within communities and co-locate services conveniently for the client.

Oakland Homeless Families Program

Organizational Issues

The Oakland Homeless Families Program (OHFP) is a service-enriched housing program for multiproblem, homeless families. The program is funded by the Robert Wood Johnson Foundation, the U.S. Department of Housing and Urban Development, and several foundations. It is one of nine national pilot projects that will demonstrate the effectiveness of coupling permanent housing and support services for homeless families.

The program is administered by the Alameda County Health Care Service Agency's Health Care for the Homeless Program, and includes the participation of over two dozen county service providers, homeless agencies, and nonprofit housing developers. Principal participating agencies include Alameda County Departments of Alcohol and Drug Services, Mental Health Services, Medical Social Services, and Social Services; Berkeley Oakland Support Services; Traveler's Aid/Homeplace Family Center; Jobs for the Homeless Consortium; and the Oakland Housing Authority.

The impetus for the OHFP stems from the realization on the part of government officials and community providers alike that the problems and needs of homeless families, while very diverse, are interrelated. Programs in the past that have provided services alone have had limited success in maintaining changed lifestyles because the environmental forces one must face while homeless only reinforce problem behaviors. Similarly, the provision of permanent housing to homeless families without support services results in many families returning to the streets.

Points of Entry

The population eligible for the Homeless Families Program will be families with one or more children who identify themselves as Oakland residents, are currently homeless, and, in addition to lack of a home, have at least one of the following conditions:

- One or more members has a significant alcohol or other drug problem
- One or more members has a major mental health history, or a developmental or physical disability
- The family has a combination of social, educational, and other problems so severe that the family has been homeless for at least 12 of the preceding 24 months.

Points of entry are through mobile outreach, Highland General Hospital, two community service centers, and participating service providers.

Service Delivery

The OHFP provides a vast array of treatment, case management, medical, and support services in conjunction with permanent housing to address the needs of homeless families in a comprehensive manner. Most services are available at a single site to minimize the time, effort, and expenses of traveling to various locations. All services will be made available to participating families over the life of the project.

Permanent housing will be provided through a mix of tenant-based and project-based Section 8 Certificates administered by the Oakland Housing Authority.

The major components of the Oakland Homeless Families Programs are:

- Case Management--The core of the Homeless Families Program is a strong case management component which emphasizes frequent home visits, individualized case planning, and a service strategy aimed at empowering participants to gain control over their lives; to develop social, family, and personal resources; and to foster positive, nurturing relationships among family members. The ratio of case managers to participants is 1:25.

- Residential Recovery Services--Two recovery centers with a total of 30 beds will be provided for women and their newborns and pregnant women with severe alcohol and other drug problems. Each center will provide up to 6 months of residential treatment.

- Community Service Center--The central location for service delivery will be two community service centers, one at Homeplace Family Center and administered by BOSS for homeless families, and the other for pregnant and parenting women and their families with alcohol and drug-related problems. This second site is funded by the California Perinatal Substance Abuse Pilot project. Except for the day treatment services offered at the Perinatal Pilot Project, the services offered at each site will be similar and will include drug recovery services, parenting education, child development services, health care, family planning, education and employment assistance, transportation, and child care.

- Housing Services--Up to 148 homeless families will be given Section 8 Certificates. All participating families will be assisted by the full-time OHFP Housing Coordinator in accessing available move-in resources, and locating and obtaining the most suitable housing for their needs.

Coordination and Effectiveness of Services

Case management is the core component of the program and is described in more detail above.

OHFP must respond to the process and outcome evaluation concerns of the numerous funders involved in the effort. All participating organizations will use common intake forms, client service and referral logs, and client outcome records. In addition, this information will be used to revise service strategies on an ongoing basis.

Financial Issues

Funding for the Oakland Homeless Families Program includes $300,000 in grant funding and a $600,000 community match over 2 years for services and administration, $140,000 in grant funding for 1 year for enhanced perinatal services, and $5,000,000 in 6-year Section 8 housing certificates.

Staffing

Staff includes both direct and contracted personnel. There are four direct program staff: a program director, housing coordinator, program assistant for perinatal services, and a secretary.

Issues and Barriers Identified

At the time of the site visit the program had not yet begun, so no issue barriers were identified.

Alameda County Health Care Service Agency
Health Care for the Homeless Program

Organizational Issues

The Alameda County Health Care for the Homeless Program (HCHP) is an interdisciplinary program that administers a variety of services to aid homeless people including mobile and clinic-based primary care services, alcohol and drug recovery services, and support services. In its most recent year, the program served over 9,000 unduplicated participants and provided 30,000 participant contacts. In addition, the program also administers the Oakland Homeless Families Program, a demonstration pilot project. (This program is described separately.)

HCHP, created in 1987, has received Federal McKinney Health Care for the Homeless funding since 1988. Administratively, the program is located within the Alameda County Health Care Services Agency, where it operates with significant autonomy and direct communication with the agency director.

The Alameda County HCHP is unique in the diversity of its service providers, the linkages it has established with community organizations, and the funding sources it utilizes to provide a comprehensive array of services for homeless people. In addition to its primary care and drug recovery subcontractors, the program maintains linkages with over 60 health and social service providers who participate in the Health Care for the Homeless Advisory Committee.

Points of Entry

HCHP provides services to all persons who are homeless or who have been homeless in the previous year and seen by the program. The program may also serve individuals or families who are in doubled-up housing situations.

HCHP performs outreach to homeless people at the locations where the homeless tend to gather, such as shelters and parks. Primary care services are provided at these sites and referrals are made to other services on an as-needed basis. HCHP also publicizes its services in a variety of ways; for example, the program distributes a "yellow pages" directory of homeless services to shelters that includes a service matrix, directory of providers by geographical area, and list of emergency service referrals.

Service Delivery

HCHP provides three main types of services: primary care, alcohol and drug recovery services, and support services. Primary care services are provided in two ways, through HCHP's mobile van and through community-based primary care centers that subcontract with HCHP to offer homeless clients drop-in or same/next-day care. The mobile van travels to 16 shelters, 2 city parks, and 2 alcohol and drug recovery centers on a regular basis. Services offered by the van include preventive and screening measures, treatment of primary care conditions, and health promotion. Among the many specific services provided by mobile van staff are EPSDT screenings for children, immunizations, child growth and developmental assessments, medications, service referrals, transportation to high-risk perinatal care, and advocacy that includes assisting homeless pregnant and parenting women in obtaining WIC.

HCHP subcontracts with 10 community health clinics and a county health center to provide clinic care to homeless people on a fee-for-service basis. Unlike the general population, who often must wait for 4 to 6 weeks for an appointment, homeless clients are often seen on the same day they are referred to the clinic. HCHP funds a case manager to coordinate services for homeless clients at these clinic sites.

The program also subcontracts with two alcohol and drug recovery programs to provide community-based, social model drug treatment services. When mobile van staff identify an individual with substance abuse problems, they refer the individual to these treatment services.

Finally, HCHP provides a broad array of outreach, advocacy, and support services to homeless individuals and families. The services include case management; housing, financial, benefits, employment, and food assistance; linkages to public health nursing and mental health services; transportation to services; and some provider training.

In addition to these general services, by piecing together five different demonstration programs, HCHP assisted in the development of a comprehensive package of services resulting in $2 million worth of services for 350 multi-problem families. The program, called Options for Recovery, focuses on serving those women who are pregnant, possibly homeless, and/or have children up to age 3. The various pieces of the program include foundation-funded enhanced homeless perinatal services, a State-funded perinatal pilot project, Federally funded services for pregnant and postpartum women, and the Robert Wood Johnson-funded Oakland Homeless Families Program.

There is no limit to the duration of services as long as the person is currently homeless. The client may continue to be seen for up to one year after finding housing.

Coordination and Effectiveness of Services

All homeless clients served receive both a health and a social service assessment of their needs. If clients are referred to contracted or outside services, transportation may be provided. At some sites, case managers are outstationed. Case managers are responsible for initial intakes, referrals to appropriate services, advocacy, and followup with clients.

HCHP evaluates the effectiveness of its services through the collection of service data, site reviews with contractors to assess contract compliance, surveys of client satisfaction, and a quality assurance program. In its four years of operation, the program has increased its client caseload from 4,500 to 9,000 users and its service units from 11,000 to 30,000 visits. In addition, the program has gained widespread credibility and acceptance within the provider community and among homeless people.

Financial Issues

The Alameda County HCHP provides a total of $1.3 million in services. The main source of funding is McKinney Section 340 Health Care for the Homeless dollars, which in 1990 amounted to $883,000. In addition, the program has pieced together grant funding from the Federal Office for Substance Abuse, the U.S. Department of Housing and Urban Development, the State, and numerous foundations, including the Better Homes Foundation, Hewlett Foundation, Kaiser Family Fund, Koret Foundation, Ronald McDonald Children's Charities, San Francisco Foundation, and Robert Wood Johnson Foundation.

Staffing

HCHP contracts out close to one-half of its McKinney dollars. Direct program staff include 10 individuals in the main office and 4 mobile van staff. In addition to their regular caseloads, 3 community health workers operate in the field on a part-time basis, meeting the van at its various service locations. Finally, the program funds public health nurses, mental health specialists, and additional case managers and alcohol and drug counselors at its various service sites.

Barriers and Issues Identified

The HCHP director feels that the mainstream health care system is unable to serve homeless individuals well because it is unable to provide the concentration and comprehensiveness of services that the homeless need. While other services for homeless people are best handled in the mainstream service system, in order to provide appropriate service delivery, health care must operate to a certain extent as a dedicated program.

The funding process for McKinney Health Care for the Homeless Programs is frustrating for program administrators. Specific problems cited include inconsistent and frequent (i.e. annual) funding cycles; inadequate and unstable appropriation levels; and the matching fund requirement, which recently increased from 25 to 33 percent. All of these problems threaten to undermine a program that homeless service providers feel is working well, largely because it provides such flexible funding.

To a large extent, HCHP's ability to link together both grant funding and service pieces into a more comprehensive service package is due to Alameda County's strong network of homeless service providers and the collaborative relationship between HCHP and its community-based partners in service provision.

Appendix A

Glossary of Terms

Glossary of Terms

Aid to Families with Dependent Children (AFDC). AFDC is the main Federal-State income support program for poor families. All States must provide AFDC benefits, which are based on a State needs standard. Eligibility is based on State-defined criteria. The State's costs for the program are matched by the Federal government at rates ranging from 50 percent to 80 percent. AFDC is an entitlement program--that is, all persons who meet the eligibility criteria receive benefits.

AFDC-Emergency Assistance (EA). Emergency Assistance is a component of the AFDC program that provides short-term emergency assistance to families who have undergone a crisis that causes an immediate need for housing. This is an optional program in which 28 States participate. The Federal government matches State funding at a 50 percent rate. Families do not have to be AFDC recipients to participate in the EA program; however, they must meet State-defined eligibility criteria. EA funding is typically used by the States to cover such costs as emergency shelter, first and last month's rent and security deposits, and rent arrearages. Federal regulations limit a family's participation in the EA program to 90 days within a 12-month period. States may expand these limits at their own cost.

Dedicated/targeted services. This term refers to services that are specifically designed to meet the needs of homeless families as opposed to **mainstream services**, defined below, which are accessible to both homeless and nonhomeless low-income people.

Emergency shelter. Short-term accommodations or food and accommodations for persons who are homeless.

Fair market rent (FMR). Rent levels established by the Federal Department of Housing and Urban Development (HUD) to determine subsidy levels for Section 8 certificates. FMRs are established for various family sizes for each metropolitan area and non-metropolitan counties on an annual basis.

Job Opportunities and Basic Skills (JOBS) Training Program. An employment and training program for AFDC recipients mandated as part of welfare reform under the Family Support Act of 1988. States must establish JOBS programs but have considerable flexibility in structuring the program to meet the specific needs of their AFDC recipient populations. JOBS programs in each State frequently go by a State-specific name.

Job Training Partnership Act (JTPA). A program enacted in 1983 to provide employment and training services to low-income people, including AFDC recipients. It established a partnership between the public and private sectors to provide job training and other employment-related skills to low income people and to help the private sector obtain a well-trained work force. It is administered through local Private Industry Councils (PICs) composed of representatives from local business, government, organized labor and others.

Mainstream services. Services designed to address the health, education and welfare needs of the general public. Such services include, among others, schools, employment and training programs, health clinics, income support programs, child day care, and social services.

McKinney Act. Abbreviated reference to the Stewart B. McKinney Homeless Assistance Act, which was signed into law in July 1987 and has since been reauthorized. Selected provisions of the Act were revised in 1990 by the National Affordable Housing Act of 1990. The McKinney Act authorizes a variety of separate programs operated by seven Federal agencies to target the problems experienced by persons who are homeless. These programs address a broad range of service needs including, among others, emergency food and shelter, transitional and longer-term housing, primary and mental health care services, education, job training, and alcohol and drug abuse programs. McKinney Act funds are distributed through formula grants to States, counties, and cities, and through competitive grants to governments or service providers.

Permanent Housing. Long-term housing including public housing, subsidized housing, and private housing.

Project Self-Sufficiency. A now completed HUD demonstration project that used Section 8 certificates as part of a package of support services to help low-income single parents become self-supporting. In some locations, the Project Self-Sufficiency functions have been assumed by State or local agencies; however, no new Section 8 certificates are being issued under this program. A successor HUD program, Operation Bootstrap, is currently operating in several locations throughout the country.

Public housing. Federally-funded housing owned and managed by local public housing authorities to provide housing for families whose income is too low to rent housing in the private housing market.

Section 8. The Section 8 certificate and voucher rental assistance programs are housing subsidy programs funded through HUD and administered through local public housing authorities. Families, elderly, handicapped, and disabled individuals who meet certain income criteria are eligible for the program. Under the Section 8 *certificate* program, eligible tenants may rent units that are priced at or below the HUD-established fair market rent (FMR) for the area. Thirty percent of a tenant's adjusted income is contributed to the rent; HUD pays the landlord the difference between the tenant's share and the FMR. Under the Section 8 *voucher* program, the local housing authority pays the landlord the difference between 30 percent of the tenant's adjusted income and a HUD-established payment standard similar to the FMR. However, tenants may choose units that exceed the payment standard so long as they pay the difference. If the rent is below the payment standard, the tenant is allowed to keep the difference.

Services-enriched housing. Permanent housing that includes the provision of coordinated long-term support services (e.g., training, child care, counseling) either onsite or through links to offsite programs. The duration, mix, and intensity of services may vary with the needs of the participant.

Transitional housing. Temporary housing that serves as an interim step to permanent housing. It usually has a longer duration than emergency shelter and includes the provision of intensive services to address participants' personal problems and assist them in maintaining independent lives.

The 707 Rental Assistance Program (Boston only). The 707 program is funded through the Executive Office of Communities and Development (EOCD) and administered by the local public housing authorities. It is similar to the Federal Section 8 program. Under the 707 program, eligible tenants may rent units that are priced within the maximum allowable rents established by EOCD. Units must pass inspection by Board of Health or local housing authority. Tenants pay no more than 25 percent of their income for rent and utilities, and the local housing authority subsidizes the difference between the tenant's share and the EOCD-established allowable rent.